

5686

05698

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 223-

1. PLACE OF DEATH:

COUNTY

Montgomery

MARYLAND

CITY (If outside corporate limits, write
OR and give nearest town)

17 TOWN Tokoma Park.

LENGTH OF STAY
(in this place)

10 Mo's

HOSPITAL OR
INSTITUTION OR
STREET ADDRESS

00 7417 BALTIMORE AVE

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE

Maryland

COUNTY

Montgomery

CITY (If outside corporate limits write RURAL and give nearest town)

OR TOWN Tokoma Park 17

STREET ADDRESS (If rural, give location)

7417-Baltimore Ave

3. NAME OF
DECEASED:
(Type or Print)

(First)

(Middle)

(Last)

Raymond

AZbell

4. DATE
OF
DEATH

(Month)

(Day)

(Year)

JUNE

6

19 55

5. SEX:

Male

6. COLOR OR
RACE:

W.

7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify):

Single

8. DATE OF BIRTH:

April 2-1922

9. AGE last birthday:

33

yrs.

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of
work done during most of work life,
even if retired):

apprentice Engineer

10b. KIND OF BUSINESS OR
INDUSTRY:

Tokoma Park

11. BIRTHPLACE (State or foreign country):

Tokoma, Ohio

12. CITIZEN OF WHAT
COUNTRY?

U.S.A.

13. FATHER'S NAME:

Peter M. Azbell Jr.

14. MOTHER'S MAIDEN NAME:

Vergie Yontee

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unk.) (If Yes, give war or dates of
service)

No

16. SOCIAL SECURITY No.:

No

17. INFORMANT & ADDRESS:

Mrs. Dorothy J. Azbell

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

970.8

Immediate cause

(a)

Cardiac Failure

DUE TO

Antecedent cause(s)

Diseases or conditions, if any.

(b)

giving rise to the above cause

DUE TO

stating underlying cause last

(c)

ingestion of Depressant Drugs.

INTERVAL BETWEEN
ONSET AND DEATHII. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:

19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☒21a. EXTERNAL CAUSE WAS
PRIMARY ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH.21b. PLACE (Home, farm, factory,
OF street, office bldg., etc.,
INJURY

21c. (City or town)

(County)

(State)

21d. TIME (Month) (Day) (Year) (Hour)
OF INJURY21e. INJURY OCCURRED
While at Not while
work ☐ at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and
find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined cause ☐.

SIGNATURE

John E. Ball

CHIEF MEDICAL EXAMINER

DATE SIGNED

DEPUTY MEDICAL EXAMINER

3 June 55

ASSISTANT MEDICAL EXAM.

23. BURIAL, CREMATION,
REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL
REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

June 5 1955

J. Wilson Dodd

N. H. D. O.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUN 7 1915

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05699

5687

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Montgomery</i>		MARYLAND		STATE <i>MD.</i>		COUNTY <i>Montgomery</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>17 Towson Park</i>		LENGTH OF STAY (in this place) <i>6 years</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Towson Park 17</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>7107 Cedar Avenue</i>				STREET ADDRESS (If rural give location) <i>7107 Cedar Avenue 1</i>			
3. NAME OF DECEASED: (First) <i>EDWARD</i> (Middle) <i>C.</i> (Last) <i>BIRGE</i>				4. DATE (Month) (Day) (Year) OF DEATH: <i>June 4, 1955</i>			
5. SEX: <i>Male</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED: <i>Widowed</i>	8. DATE OF BIRTH: <i>October 31, 1855</i>	9. AGE last birthday: <i>99</i> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Town Clerk</i>		10B. KIND OF BUSINESS OR INDUSTRY: <i>Town Government</i>		11. BIRTHPLACE (State or foreign country): <i>Litchfield Co. Connecticut</i>		12. CITIZEN OF WHAT COUNTRY: <i>U.S.A.</i>	
13. FATHER'S NAME: <i>Henry G. Birge</i>				14. MOTHER'S MAIDEN NAME: <i>Rachel Coley</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <i>no</i>		16. SOCIAL SECURITY NO.:		17. INFORMANT & ADDRESS: <i>Betsy B. Matson, 7107 Cedar Ave. T.P.M.S.</i>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <i>Cardiac cessation (failure)?</i>							
ANTECEDENT CAUSE (S) <i>Senility</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <i>Fell out of bed in sleep during night but examination revealed no injury</i>						<i>Many yrs.</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <i>—</i>		19B. MAJOR FINDINGS OF OPERATION: <i>—</i>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, etc.) OF INJURY: <i>—</i>		21C. WHERE DID (City or town) INJURY OCCUR? <i>—</i>		(State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: <i>—</i>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <i>—</i>			
22. I hereby certify that I attended the deceased from <i>Jan. 1, 1952</i> to <i>June 4, 1955</i> that I last saw the deceased alive on <i>June 3, 1955</i> , and that death occurred at <i>5:30 A.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>Wm. Wood Neigjes</i>		ADDRESS <i>Wash. D.C.</i>		DATE SIGNED <i>6/4/55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THERE <i>June 8, 1955</i>		NAME OF CEMETERY OR CREMATORY <i>Green's Farm, Connecticut</i>		LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REGISTRAR <i>June 4-1955</i>		REGISTRAR'S SIGNATURE <i>J. Wilson Dotch</i>		24. FUNERAL DIRECTOR <i>J. Arthur Walters</i>		ADDRESS <i>254 Carroll St. W. H.C.</i>	

RECEIVED

JUN 6 1955

BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No. 216

5717

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY Montgomery	MARYLAND		STATE Maryland	COUNTY Montg.	
CITY (If outside corporate limits, write OR and give nearest town) Bethesda	RURAL	LENGTH OF STAY (in this place) 9 years	CITY (If outside corporate limits, write RURAL and give nearest town) Bethesda	RURAL	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 7201 Denton Road			STREET ADDRESS (If rural give location) 7201 Denton Road		
3. NAME OF DECEASED: (First) Robert (Middle) C. (Last) BOAK			4. DATE OF DEATH: (Month) June (Day) 10 (Year) 1955		
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: Dec. 13, 1878		9. AGE last birthday: 76 yrs. 5 Months 27 Days 0 Hours 0 Min.
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: Supt. - Retired Steel Co.			10b. KIND OF BUSINESS OR INDUSTRY: Steel Co.		11. BIRTHPLACE (State or foreign country): Newcastle, Penna.
13. FATHER'S NAME: James W. Boak			14. MOTHER'S MAIDEN NAME: Martha Magee		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): No			16. SOCIAL SECURITY No.: 193-03-8616A		17. INFORMANT & ADDRESS: Mrs. Josephine K. Boak-Same Item #2

18. MEDICAL CERTIFICATION				Interval Between Onset And Death	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
Immediate cause (a) CORONARY OCCLUSION				INSTANT.	
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE				5 YEARS	
(c) ATHEROSCLEROSIS, GENERALIZED				10 YEARS	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. PULMONARY EMPHYSEMA				10 YEARS	
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from SEPT. 20, 1954 , to JUNE 10, 1955 , that I last saw the deceased alive on JUNE 1, 1955 , and that death occurred at 10:30 PM , from the causes and on the date stated above.					
SIGNATURE Robert A. Angle M.D.		ADDRESS 5009 DEL RAY AVE BETHESDA MD.		DATE SIGNED 6/10/55	
23. BURIAL CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)	
Burial	6/13/55	Parklawn	Rockville	Maryland	
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR		ADDRESS	
6/13/55	Bessie M. Thompson	Robert A. Humphrey		Bethesda, Md	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

8717

Birth Country

Birth Date

7301 Denton Road

7301 Denton Road

Robert

Robert

June 19

White

Married

Dec. 1, 1919

June 19

Capt. - Reformed Steel Co.

Newcastle, Penna.

James W. Boak

Martin Mayer

100-43-3016A After Josephine I. Boak - Same Item 12

BUREAU V. S.

JUN 15 1955

RECEIVED

RECEIVED

RECEIVED

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5688 CERTIFICATE OF DEATH

05701

Reg. Dist. No. 223

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>MONTGOMERY</u>	MARYLAND	STATE <u>MD.</u>	COUNTY <u>MONTGOMERY</u>
CITY (if outside corporate limits, write RURAL and give nearest town) OR TOWN <u>TAKOMA PARK</u>	LENGTH OF STAY (in this place) <u>1 1/2 HR.</u>	CITY (if outside corporate limits, write RURAL and give nearest town) OR TOWN <u>KENSINGTON, MD.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>WASHINGTON SANITARIUM & HOSPITAL</u>	STREET ADDRESS (If rural give location) <u>3318 FERNDALE ST.</u>		
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <u>BAO</u>	(Middle)	(Last) <u>GIRL BRASWELL</u>	OF DEATH: <u>6</u> <u>2</u> <u>1955</u>
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W.</u>	7. <u>SINGLE</u> MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH: <u>6/2/55</u>
9. AGE last birthday		10. CITIZEN OF WHAT COUNTRY?	
<u>1</u> yrs. <u>1</u> Months <u>2</u> Days <u>1</u> Hours <u>29</u> Min.		<u>U. S.</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>Maryland.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME: <u>Willie Braswell Jr.</u>		14. MOTHER'S MAIDEN NAME: <u>Doris Coon</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
		17. INFORMANT & ADDRESS: <u>FATHER SAME.</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>7625 Prematurity - FETAL ATELECTASIS.</u>			
ANTECEDENT CAUSE (S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) (Minute) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>6-2</u> , 19 <u>55</u> , to <u>6-2</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>6/2/55</u> , 19 <u>55</u> , and that death occurred at <u>10:48 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>John R. Conley</u>		DATE SIGNED <u>June 4-1955</u>	
ADDRESS <u>3716 Howard Ave. Kensington, Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>June 4-1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		LOCATION (City, town, or county) (State) <u>R. R. Co. Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>June 2 1955</u>		24. FUNERAL DIRECTOR <u>The L. H. King Co. 2901-14th St. N.W.</u>	
REGISTRAR'S SIGNATURE <u>John R. Conley</u>		ADDRESS <u>2901-14th St. N.W.</u>	

2065282301

E. H. King Co.

RECEIVED

JUN 6 1955

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5702

CERTIFICATE OF DEATH

Reg. Dist. No.

216

Items 9, 13, 14 Film G183 7-2-55 et

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>D.C.</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
X TOWN <u>Bethesda</u>				TOWN <u>Washington</u> 47X-3			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
74 <u>Suburban Hospital</u>				<u>6206 Broadbranch Rd. N.W.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>CORA RABA BUELL</u>				<u>June 30 1955</u>			
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
<u>Female</u>		<u>White</u>				<u>2/8/66</u>	
9. AGE last birthday		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
<u>89</u> yrs.		Months		Days		Hours	
						Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<u>Retired</u>						<u>Ohio</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Bean</u>				<u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
						<u>3533 Cumberland St. N.W.</u> <u>Arthur C. Buell (nephew)</u>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
442X IMMEDIATE CAUSE (A) <u>Conjunctive Heart Failure</u> 1 wk.							
ANTECEDENT CAUSE (S) DUE TO (B) <u>Caecio-vascular renal disease</u> 5 yrs.							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>aspiration pneumonia</u> 2 wks.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 10 1955</u> to <u>June 30 1955</u> , that I last saw the deceased alive on <u>June 29, 1955</u> , and that death occurred at <u>5:29 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Sidney C. Cousins</u>				ADDRESS <u>M.D. 3921 Lugomer St. N.W. D.C.</u>		DATE SIGNED <u>6/30/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<u>Removal</u>		<u>7/1/55</u>		<u>Rock Creek Cem.</u>		<u>Washington D.C.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>6/30/55</u>		<u>Bernice M. Thompson</u>		<u>The W. H. Jones Co.</u>		<u>290 19th St. N.W.</u>	

BUREAU V. S.

JUL 5 1955

RECEIVED

5719

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Montgomery		MARYLAND		STATE District of Columbia		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
Bethesda Rural		17 days		Washington, D.C. 47X-3			
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Naval Hospital				STREET ADDRESS (If rural give location) 2201 Massachusetts Avenue, N.W.			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
Alexander Mazyck BULL				June 4 19 55			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Mln.
Male	White	Widowed	12-25-79	75 yrs.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Lawyer			10B. KIND OF BUSINESS OR INDUSTRY: Lawyer		11. BIRTHPLACE (State or foreign country): South Carolina		12. CITIZEN OF WHAT COUNTRY? US
13. FATHER'S NAME: William I. BULL				14. MOTHER'S MAIDEN NAME: Hattie TAYLOR			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY No.		17. INFORMANT'S ADDRESS: Son Capt William I. BULL USN Same as above		
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
158X							
IMMEDIATE CAUSE (A) Pulmonary edema						1 day	
DUE TO ANTECEDENT CAUSE (S) (B) Inferior Vena Cava Obstruction						acute	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) Retrosplenobulbar sarcoma						unknown	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 17 May, 19 55 to 4 June, 19 55 that I last saw the deceased alive on 4 June, 19 55 , and that death occurred at 3:00A M, from the causes and on the date stated above.							
SIGNATURE P. G. BAMBERG LT MC USN				DATE SIGNED U. S. Naval Hospital, NMMC, Bethesda, Maryland			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial Transit		9 June 1955		Jacksonville, Florida			
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
4 June 1955		Mary E. Parrelly		Gawlers Funeral Home		1756 Penn. Ave., N.W., Washington, D.C.	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 3

RECEIVED

JUN 13 1955

5720

CERTIFICATE OF DEATH

Reg. Dist. No. 215.....

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u> MARYLAND		STATE <u>District of Columbia</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bethesda Rural</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Washington, D.C.</u> <u>47X-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Naval Hospital</u>		STREET ADDRESS (If rural give location) <u>110 Quincy Street</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Roma</u> (N) <u>BURKE</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>June</u> <u>5</u> <u>19 55</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>Negroid</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>1-21-98</u>
9. AGE last birthday <u>57</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>Georgia</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Sheet Metal Worker Helper Industry</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>John BURKE</u>		14. MOTHER'S MAIDEN NAME: <u>Elizabeth MONTGOMERY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes</u> <u>WW I</u>		16. SOCIAL SECURITY NO.: <u>Unknown</u>	
17. INFORMANT & ADDRESS: <u>Wife Mrs. Elsie BURKE</u> <u>Same as above</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Heart Failure</u>			<u>1 day</u>
ANTECEDENT CAUSE (S) (B) <u>Hypertension</u>			<u>unknown</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Chronic glomerulonephritis</u>			<u>unknown</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>2</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>9 April, 19 55</u> to <u>5 June, 19 55</u> , that I last saw the deceased alive on <u>5 June</u> , 19 <u>55</u> , and that death occurred at <u>1140AM</u> , from the causes and on the date stated above.			
SIGNATURE <u>P. G. Bamberg</u>		ADDRESS <u>M.D. NMMC, Bethesda, Maryland</u>	
P. G. BAMBERG LT MC USN U. S. Naval Hospital		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>9 June 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>		LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5 June 1955</u>		24. FUNERAL DIRECTOR <u>Hoffman Funeral Home</u>	
REGISTRAR'S SIGNATURE <u>Mary E. Parrelly</u>		ADDRESS <u>611 K Street, N.W., Washington, D.C.</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 13 1955

BUREAU V. S.

5721

CERTIFICATE OF DEATH

Reg. Dist. No. 216...

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>Montgomery</u> MARYLAND			STATE <u>Wash., D.C.</u> COUNTY		
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			CITY (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u>		
TOWN <u>Bethesda</u>			TOWN <u>Washington, D.C.</u>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>The Clinical Center Nat'l. Inst. of Health</u>			STREET ADDRESS (If rural give location) <u>322 36th St. N.E.</u>		
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Bernard Arnold Carr</u>			4. DATE (Month) (Day) (Year) OF DEATH: <u>June 7 19 55</u>		
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>23 Jan. 1950</u>	9. AGE last birthday <u>5</u> yrs.	IF UNDER 1 YEAR Months Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Child</u>			10B. KIND OF BUSINESS OR INDUSTRY: <u>--</u>	11. BIRTHPLACE (State or foreign country): <u>Washington, D.C.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME: <u>Austin Carr</u>			14. MOTHER'S MAIDEN NAME: <u>Lula Graham</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service) <u>--</u>			16. SOCIAL SECURITY No. <u>None</u>	17. INFORMANT & ADDRESS: <u>The Medical Record, The Clinical Center</u>	
18. MEDICAL CERTIFICATION					INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
IMMEDIATE CAUSE (A) <u>Lymphosarcoma, disseminated</u>					
ANTECEDENT CAUSE (S) DUE TO					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO					
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19A. DATE OF OPERATION: <u>4 Apr. 1955</u>		19B. MAJOR FINDINGS OF OPERATION: <u>Lymphosarcoma of small intestine</u>			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.) <u>--</u>		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? <u>--</u>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>-- M.</u>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>--</u>	
22. I hereby certify that I attended the deceased from <u>May 31, 19 55</u> to <u>June 7, 19 55</u> , that I last saw the deceased alive on <u>June 7, 19 55</u> , and that death occurred at <u>7:55PM</u> , from the causes and on the date stated above.					
SIGNATURE <u>[Signature]</u>		ADDRESS <u>M. D. The Clinical Center, NIH</u>		DATE SIGNED <u>8 June 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>6-13-55</u>		DATE THEREOF <u>6-13-55</u>		NAME OF CEMETERY OR CREMATORY <u>Washington National</u>	
				LOCATION (City, town, or county) (State) <u>Washington Virginia</u>	
DATE REC'D BY LOCAL REGISTRAR <u>6/10/55</u>		REGISTRAR'S SIGNATURE <u>Beattie M. Thompson</u>		24. FUNERAL DIRECTOR ADDRESS <u>CARVER FUNERAL HOME 29-H ST. N.W.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUN 13 1955

RECEIVED

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF MARYLAND—CERTIFICATE OF DEATH

05706

1. PLACE OF DEATH

County MontgomeryRegistration Dist. No. 216Village or City Wheaton HeightsNo. 5118 Wapalona

St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred _____ yrs. _____ mos. _____ ds. How long in U. S. if of foreign birth? _____ yrs. _____ mos. _____ ds.

2. FULL NAME Irene Virginia Caton

If U. S. Veteran, specify WAR _____

(a) Residence: No. 5118 Wapalona

St., Ward.

If nonresident give city or town and State 15X-1

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>white</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>widowed</u>
-------------------------	----------------------------------	---

5e. If married, widowed, or divorced
HUSBAND of
(or) WIFE ofEnoch Francis Caton6. DATE OF BIRTH (month, day, and year) Dec. 16 1879

7. AGE <u>81</u>	Years <u>0</u>	Months	Days	If LESS than 1 day, _____ hrs. or _____ min.
---------------------	-------------------	--------	------	--

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Housewife

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month end year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Montgomery Co
(State or country) Maryland13. NAME John Hutchinson14. BIRTHPLACE (city or town) Md.
(State or country)15. MAIDEN NAME Lucinda Ann Riggs16. BIRTHPLACE (city or town) Md.
(State or country)17. INFORMANT Carie Lyons
(Address) Union Ave

18. BURIAL, CREMATION, OR REMOVAL

Place Andrew Chapel Date June 12, 196319. UNDERTAKER Philly Chas Smith
(Address) 5103 W. 9th St20. FILED 6/7/63 St. Basil M. Thompson
Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH

<u>June</u> (Month)	<u>7</u> (Day)	<u>1963</u> (Year)
------------------------	-------------------	-----------------------

22. I HEREBY CERTIFY, That I attended deceased from 2/24 1950 to 6/7 1963I last saw her alive on 6/6 1963; death is saidto have occurred on the date stated above, at 10:20 a.m.

The PRINCIPAL CAUSE OF DEATH and related causes of Importance were as follows:

Cerebral hemorrhage
Arteriosclerotic cardiac vascular
disease422.1

Date of onset

Other Contributory Causes of Importance:

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? no

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____

(Specify city or town, county and State)
Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of Injury _____

Nature of Injury _____

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify _____

(Signed) Nelson P. C. Crick

M. D.

(Address) Falls Church Va.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
<i>Arteriosclerosis</i>	<i>1915</i>
<i>Chronic interstitial nephritis</i>	<i>1921</i>
<i>Cerebral hemorrhage</i>	<i>July 5, 1927</i>
Other contributory causes of importance:	
<i>Gallstones</i>	<i>May 1, 1923</i>

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
<i>Attack of epilepsy</i>	<i>1 week ago</i>
<i>Run over by street car</i>	<i>1 week ago</i>
<i>Peritonitis</i>	<i>3 days ago</i>
Other contributory causes of importance:	
<i>Gastroenteritis</i>	<i>1 year</i>

5561 6 NH ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

RECEIVED

5723

05707

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 216

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Montgomery</u>
CITY (If outside corporate limits, write OR and give nearest town) <u>Bethesda</u>	LENGTH OF STAY (in this place) <u>80A</u>	CITY (If outside corporate limits write RURAL and give nearest town) <u>Silver Spring</u>	<u>56</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban</u>		STREET ADDRESS <u>4308 Garrett Park Rd.</u>	(If rural, give location)
3. NAME OF DECEASED: (First) <u>Paul</u> (Middle) <u>Warren</u> (Last) <u>Cobell</u>		4. DATE OF DEATH (Month) <u>June</u> (Day) <u>15</u> (Year) <u>1955</u>	
5. SEX: <u>M.</u>	6. COLOR OR RACE: <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>M</u>	8. DATE OF BIRTH: <u>6/1/21</u>
9. AGE last birthday: <u>34</u> yrs.		IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Business Helper (unemployed)</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Washington D.C.</u>	
11. BIRTHPLACE (State or foreign country): <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Paul A. Cobell</u>		14. MOTHER'S MAIDEN NAME: <u>Mary Lewis</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>yes</u> (If Yes, give war or dates of service) <u>WW II</u>		16. SOCIAL SECURITY No.: <u>Yes</u>	
17. INFORMANT & ADDRESS: <u>Helene Cobell (wife) Same as Jun 2</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
430.1 Immediate cause (a) <u>Coronary occlusion</u>		<u>Sudden</u>
DUE TO		
Antecedent cause(s) (b) <u>DUE TO</u>		
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY	21c. (City or town) (County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		
SIGNATURE <u>Donald J. Brunschart</u>		DATE SIGNED <u>6-15-55</u>
M. D. CHIEF MEDICAL EXAMINER <u>Warner E. Humphrey</u>		DEPUTY MEDICAL EXAMINER
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>June 17, 1955</u>
NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>		LOCATION (City, town, or county) (State) <u>Fort Myer, Va.</u>
DATE REC'D BY LOCAL REG. <u>6/18/55</u>		24. FUNERAL DIRECTOR <u>Warner E. Humphrey</u>
REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		ADDRESS <u>Silver Spring, Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 21 1955

BUREAU V. S.

5724

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH: COUNTY <u>8825-1st ave</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> TOWN <u>1 week</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Montgomery</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring Md.</u> TOWN <u>56</u> STREET ADDRESS (If rural give location) <u>8825-1st ave.</u>	
3. NAME OF DECEASED: (Type or Print) (First) (Middle) (Last) <u>William Stockton Colburn</u>		4. DATE OF DEATH: (Month) (Day) (Year) <u>June - 14</u> 19 <u>55</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>Dec - 17 - 1890</u>
9. AGE last birthday: <u>64</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
11a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>Sunday</u>		11b. KIND OF BUSINESS OR INDUSTRY: <u>Retired</u>	
12. CITIZEN OF WHAT COUNTRY: <u>U.S.</u>		13. BIRTHPLACE (State or foreign country): <u>Washington D.C.</u>	
14. FATHER'S NAME: <u>Winfield Colburn</u>		15. MOTHER'S MAIDEN NAME: <u>unknown</u>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>USA 1st</u>		17. SOCIAL SECURITY No.: <u>482-1st</u>	
18. INFORMANT & ADDRESS: <u>Mrs Viola Colburn Bayton Beach Fla.</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Interval Between Onset And Death
Immediate cause (a) <u>Coronary Thrombosis</u>		<u>2 hrs.</u>
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u>		<u>2-3 yrs.</u>
(c)		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) PLACE (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/> HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from <u>January, 1938</u> , to <u>June 14, 1955</u> , that I last saw the deceased alive on <u>June 14, 1955</u> , and that death occurred at <u>7:00 PM</u> , from the causes and on the date stated above.			
SIGNATURE (Degree or title) <u>W. W. Wadsworth M.D.</u>		ADDRESS <u>837 Bonaventure St. Silver Spring Md.</u> DATE SIGNED <u>June 14, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF <u>6/17/55</u>	NAME OF CEMETERY OR CREMATORY <u>Arlington Natl. Cem.</u>	LOCATION (City, town, or county) (State) <u>Arlington Va.</u>
DATE REC'D BY LOCAL REGISTRAR <u>6-17/55</u>	REGISTRAR'S SIGNATURE <u>Francis Potter</u>	24. FUNERAL DIRECTOR <u>S. H. Hines Co</u>	ADDRESS <u>2901-14th St. N.W. D.C.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 20 1955

BUREAU V. S.

5725

05709

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 214

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>MD</u>	COUNTY <u>Montg</u>
CITY (If outside corporate limits, write OR and give nearest town) <u>56 Silver Spring</u>	LENGTH OF STAY (in this place) <u>7 yrs</u>	CITY (If outside corporate limits write RURAL and give nearest town) <u>56 Silver Spring</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2412 Penny Rd</u>		STREET ADDRESS (If rural, give location) <u>2412 Penny Rd</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <u>John</u>	(Middle) <u>Kenneth</u>	(Last) <u>Collins</u>	(Month) <u>June</u> (Day) <u>19</u> (Year) <u>1955</u>
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>July 7 1910</u>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>O & I Air Force</u>		10b. KIND OF BUSINESS OR INDUSTRY:	9. AGE last birthday: <u>44</u> yrs.
11. BIRTHPLACE (State or foreign country): <u>Wash. DC</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>J. Bernard Collins</u>		14. MOTHER'S MAIDEN NAME: <u>Mary McLouchin</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:	
		17. INFORMANT & ADDRESS: <u>Mary Collins (wife) Same as Item 2</u>	

18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			
Immediate cause (a) <u>Coronary occlusion</u> DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)			<u>Sudden</u>
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <u>Frank J. Broschart</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/> <u>6-19-55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	DATE THEREOF <u>6-22-55</u>	NAME OF CEMETERY OR CREMATORY <u>mt Olivet</u>	LOCATION (City, town, or county) (State) <u>Wash. DC.</u>
DATE REC'D BY LOCAL REG. <u>6-22-55</u>	REGISTRAR'S SIGNATURE <u>Francis J. Collins</u>	24. FUNERAL DIRECTOR ADDRESS <u>Francis J. Collins 3821-44th St NW Wash. DC.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 24 1955

BUREAU V. E.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5726

CERTIFICATE OF DEATH

Reg. Dist. No. 213

05710

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Montgomery</u>
CITY (If outside corporate limits, write RURAL or and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural-Potomac</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Home</u>	STREET ADDRESS (If rural give location) <u>RT.# 3, Bethesda, Md.</u>		
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>JOHN RICHARD COLLINS</u>		DEATH: <u>June 23, 19 55</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>9-12-1865</u>
9. AGE last birthday <u>89</u> yrs.		IF UNDER 1 YEAR: Months <u>9</u> Days <u>11</u>	IF UNDER 24 HRS.: Hours <u>11</u> Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Ret. Farmer</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Self Emp.</u>	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME: <u>Richard Collins</u>		14. MOTHER'S MAIDEN NAME: <u>Sarah Jane Houser</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT & ADDRESS: <u>Mrs Archie Cottingham-Item# 2</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Myocardial failure</u>			<u>2 weeks.</u>
ANTECEDENT CAUSE (S) <u>Senile arteriosclerosis</u>			<u>5 years</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>None.</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>None</u>	19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>1950</u> , to <u>June 23, 1955</u> , that I last saw the deceased alive on <u>June 23, 1955</u> , and that death occurred at <u>7:47 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>J. H. Linticum</u>		DATE SIGNED <u>June 23, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>6-26-55</u>	NAME OF CEMETERY OR CREMATORY <u>Potomac Church Cem.</u>
LOCATION (City, town, or county) (State) <u>Potomac, Maryland</u>			
DATE REC'D BY LOCAL REGISTRAR <u>6/28/55</u>		REGISTRAR'S SIGNATURE <u>Laurel H. Bryant</u>	24. FUNERAL DIRECTOR <u>Robert A. Humphrey</u>
ADDRESS <u>Bethesda, Md.</u>			

RECEIVED

JUN 29 1955

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5727

05711

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Missouri</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
<u>TOWN Bethesda Rural</u>		<u>4 days</u>		<u>TOWN Osborn</u> <u>62 X-3</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Naval Hospital</u>				STREET ADDRESS (If rural, give location) <u>✓</u>			
3. NAME OF DECEASED:				4. DATE OF DEATH			
(First) <u>Virginia</u>		(Middle) <u>Ester</u>		(Last) <u>COOK</u>		(Month) (Day) (Year) <u>June 27 19 55</u>	
(Type or Print)							
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
<u>Female</u>		<u>White</u>		<u>Married</u>		<u>9-24-23</u>	
9. AGE last birthday:				10. BIRTHPLACE (State or foreign country):			
<u>31 yrs.</u>				<u>Missouri</u>			
11. CITIZEN OF WHAT COUNTRY?				12. CITIZEN OF WHAT COUNTRY?			
<u>U. S.</u>				<u>U. S.</u>			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Forrest Rodgers</u>				<u>Ester Groebe</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, po, or unk.)				16. SOCIAL SECURITY No.:			
<u>No</u>				<u>Unknown</u>			
17. INFORMANT & ADDRESS:				18. MEDICAL CERTIFICATION			
<u>Husband Leo S. COOK</u>				19. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			
<u>5705 Wingate Drive, Bethesda, Maryland</u>				20. INTERVAL BETWEEN ONSET AND DEATH			
				<u>16 1/2 days</u>			
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				21b. PLACE (Home, farm, factory, street, office bldg., etc., OF INJURY)			
				<u>Rich Creek on Bluefield</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY				21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>			
<u>6-10-55 11 P. M.</u>				<u>1</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .				22. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
SIGNATURE <u>Frank J. Brochant</u>				DATE SIGNED <u>6-27-55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify):				24. FUNERAL DIRECTOR			
<u>Burial</u>				<u>Chief Medical Examiner</u>			
<u>7-2-55</u>				<u>Deputy Medical Examiner</u>			
<u>Osborn</u>				<u>Assistant Medical Exam.</u>			
<u>Osborn, Missouri</u>				<u>6-27-55</u>			
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE				ADDRESS			
<u>6-27-55</u>				<u>B. A. Humphrey Funeral Home</u>			
				<u>7557 Wisconsin Avenue, Bethesda, Maryland</u>			

RECEIVED
JUN 28 1955
BUREAU V. 8

RECEIVED

JUN 28 1955

BUREAU V. 8

5728

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>District of Columbia</u>			
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
X <u>Bethesda Rural</u>		<u>Thrs 40 min</u>		<u>Washington, D.C.</u>		<u>47X-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Naval Hospital</u>				STREET ADDRESS (If rural give location) <u>3565 Brandywine Street, N.W.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>Robert Bruce CRICHTON</u>				<u>June 21 19 55</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>3-25-96</u>	<u>59 yrs.</u>	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Mariner Retired</u>		<u>Mariner</u>		<u>Iowa</u>		<u>US</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Robert A. CRICHTON</u>				<u>Mary E. ADAMS</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
<u>Yes</u> (If Yes, give war or dates of service) <u>WW II WW I</u>		<u>Unknown</u>		<u>Wife Mrs. Maud W. CRICHTON</u> <u>Same as above</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<u>420.1</u>							
IMMEDIATE CAUSE (A) DUE TO							
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>21 Jun., 19 55</u> , to <u>21 Jun., 19 55</u> that I last saw the deceased alive on <u>21 Jun., 19 55</u> , and that death occurred at <u>2:55 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>J. R. DAVIS</u>		ADDRESS <u>U. S. Naval Hospital, NMMC, Bethesda, Maryland</u>		DATE SIGNED			
23. BURIAL CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Buried</u>		<u>24 Jun 1955</u>		<u>Arlington National Cemetery</u>		<u>Arlington, Virginia</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>22 June 1955</u>		<u>Mary E. Crassey</u>		<u>R. A. Humphrey Funeral Home</u>		<u>7557 Wisconsin Avenue, Bethesda, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUN 24 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05713

5729

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Montgomery MARYLAND		STATE Maryland COUNTY Montgomery	
CITY (If outside corporate limits, write RURAL and give nearest town) Germantown		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Spring	
HOSPITAL OR INSTITUTION OR STREET ADDRESS The Marylander Rest Home		STREET ADDRESS (If rural give location) 931 Northampton Drive	
3. NAME OF DECEASED: (First) Mary (Middle) A. (Last) CUFFS		4. DATE (Month) (Day) (Year) OF DEATH: June 8, 19 55	
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Single	8. DATE OF BIRTH: Dec. 16, 1874
9. AGE last birthday 80 yrs.		10. IF UNDER 1 YEAR: Months 5 Days 22 Hours Min. 	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Teacher		10B. KIND OF BUSINESS OR INDUSTRY: Education	
11. BIRTHPLACE (State or foreign country): District of Columbia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: M. Cuffs		14. MOTHER'S MAIDEN NAME: Elizabeth McMahon	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT & ADDRESS: Isabel Smith - Same Item #2 (Sister)			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) Coronary occlusion			Immediately
ANTECEDENT CAUSE (S) DUE TO (B) coronary arteriosclerosis			8 years.
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY: YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from March, 1955 , to June 8, 1955 , that I last saw the deceased alive on June 7, 1955 , and that death occurred at 8:30 A.M. from the causes and on the date stated above.			
SIGNATURE Samuel E. Martena		DATE SIGNED June 8, 1955	
ADDRESS M. D. German Town			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial-transit		DATE THEREOF 6/8/55	
NAME OF CEMETERY OR CREMATORY Holy Rood		LOCATION (City, town, or county) (State) Naussau Co. L. I. New York	
DATE REC'D BY LOCAL REGISTRAR June 8, 1955		REGISTRAR'S SIGNATURE Abraham G. Cooke	
24. JUNEAL DIRECTOR Robert R. Humphrey		ADDRESS Bethesda, Md.	

RECEIVED
JUN 14 1955
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5730

05714

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 516

Reg. Dist.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Montgomery</u> COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Beltsville</u>		<u>2000</u>		TOWN <u>Silver Spring</u> <u>56</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital</u>				STREET ADDRESS (If rural, give location) <u>1512 Wheaton Lane</u>			
3. NAME OF DECEASED:		(First) <u>Ferdinando</u>		(Middle) <u>Curradi</u>		(Last) <u>Curradi</u>	
(Type or Print)						4. DATE OF DEATH <u>June 26 19 55</u>	
5. SEX: <u>M.</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH: <u>8/15/83</u>	9. AGE last birthday: <u>70</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months Days		Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Retired Italian Govt. RR</u>		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Florence Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>Italy</u>	
13. FATHER'S NAME: <u>Carlo Curradi</u>				14. MOTHER'S MAIDEN NAME: <u>Assunta Valecchi</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <u>none</u>		17. INFORMANT & ADDRESS: <u>Mrs. Maria Fields, Daughter, same address</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause (a) <u>Coronary occlusion</u> DUE TO <u>11:27 A.M.</u>							
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO <u>under death</u>							
stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: <u>Arteriosclerosis</u>							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Frank B. Bruchant</u>		CHIEF MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER		DATE SIGNED <u>6-26-55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>6/29/55</u>		NAME OF CEMETERY OR CREMATORY <u>St. John's Cemetery</u>		LOCATION (City, town, or county) (State) <u>Montgomery County, Md.</u>	
DATE REC'D BY LOCAL REG. <u>6/28/55</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		24. FUNERAL DIRECTOR <u>Warren B. Humphrey</u>		ADDRESS <u>8434 Ga. Ave. Silver Spring, Md.</u>	

BUREAU V. S.

JUN 30 1955

RECEIVED
ED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5731

05715

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 216

Reg. Dist.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)		OR	
TOWN <u>Bethesda 14,</u>		<u>8 hrs 42 mins</u>		TOWN <u>Rockville</u>		<u>26</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital</u>				STREET ADDRESS (If rural, give location) <u>5714 Crawford Drive</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>MARGARET Keary Cushman</u>				<u>June 27 19 55</u>			
5. SEX:	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Female</u>	<u>white</u>	<u>married</u>	<u>March 5, 1881</u>	<u>74</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>James T. Keary</u>				14. MOTHER'S MAIDEN NAME: <u>Slue Parsons</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>Fred B. Cushman - husband - as above</u>			
(If Yes, give war or dates of service)							
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
(a) <u>331X Immediate cause</u>						<u>13 hrs</u>	
(b) <u>Antecedent cause(s)</u>						<u>13 hrs</u>	
(c) <u>Diseases or conditions, if any, giving rise to the above cause stating underlying cause last</u>						<u>? years</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: <u>Generalized arteriosclerosis, mild</u>						<u>7 years</u>	
19. DATE OF OPERATION: <u>June 27 1955</u>				20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. PLACE (Home, farm, factory, OF street office bldg., etc., INJURY <u>home</u>)		21c. (City or town) (County) (State) <u>Rockville Monty Md</u>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>6-27-55 5:30 A.M.</u>				21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Fell in bath room of her home</u>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Frank J. Brant</u>				M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>				DATE THEREOF <u>6-30-55</u>		NAME OF CEMETERY OR CREMATORY <u>Forest Oak</u>	
LOCATION (City, town, or county) (State) <u>Laurel Md</u>				24. FUNERAL DIRECTOR <u>Ernest C. Farnum</u>			
DATE REC'D BY LOCAL REG. <u>June 29 1955</u>				REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>			
ADDRESS <u>7/2/55</u>							

RECEIVED

JUL 6 1955

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05716

5732

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE --		COUNTY --	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bethesda</u>		LENGTH OF STAY (in this place) <u>1 day</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Washington, D. C.</u> <u>47 X-3</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>50 The Clinical Center Natl. Institutes of Health</u>				STREET ADDRESS (If rural give location) <u>4608 Sargent Road, N.E.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Dorothy Agnes Dolan</u>				4. DATE OF DEATH: (Month) (Day) (Year) <u>June 29 19 55</u>			
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>March 29, 1906</u>	9. AGE last birthday <u>49</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>--</u>		11. BIRTHPLACE (State or foreign country): <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Andrew J. Gleeson</u>				14. MOTHER'S MAIDEN NAME: <u>Annie C. Cosgrove</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>None</u>		17. INFORMANT & ADDRESS: <u>The medical record, The Clinical Center</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Metastatic breast adenocarcinoma of the brain</u>							
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Bronchopneumonia</u>							
19A. DATE OF OPERATION: <u>--</u>		19B. MAJOR FINDINGS OF OPERATION: <u>--</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>--</u> M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>--</u>			
22. I hereby certify that I attended the deceased from <u>June 28, 1955</u> , to <u>June 29, 1955</u> , that I last saw the deceased alive on <u>June 29, 1955</u> , and that death occurred at <u>2:15 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Harold Altman, M.D.</u>		ADDRESS <u>The Clinical Center Natl. Institutes of Health</u>		DATE SIGNED <u>6/29/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>July 2, 1955</u>		DATE THEREOF <u>July 2, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>		LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>6/30/55</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		24. FUNERAL DIRECTOR <u>James J. Gelineau</u>		ADDRESS <u>3821-14th St. N.W. Wash. D.C.</u>	

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JUL 5 1955

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5733

05717
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Montgomery</i>		MARYLAND		STATE <i>Md</i>		COUNTY <i>Monty</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)		OR	
TOWN <i>Bethesda</i>		<i>D.C.A.</i>		TOWN <i>Cherry Chase</i>		<i>X</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>9000 Block 7 looks Rd</i>				STREET ADDRESS (If rural, give location) <i>5620 Grove St.</i>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<i>John Francis Donohoe</i>				<i>June 5 1955</i>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR		
<i>Male</i>	<i>White</i>	<i>Married</i>	<i>Aug 8 1913</i>	<i>41</i> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <i>Real Estate Agent</i>				10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <i>Washington DC</i>	
13. FATHER'S NAME: <i>Clarence F. Donohoe</i>				14. MOTHER'S MAIDEN NAME: <i>Clara Hurtt</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>m</i> (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <i>Hilda R. Donohoe (wife) Same as him</i>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
Immediate cause (a) <i>Cerebral hemorrhage</i> DUE TO Antecedent cause(s) (b) <i>Compound fracture of skull</i> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c) <i>self inflicted shot gun wound</i>		<i>Sudden</i>
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <i>Home</i>	21c. (City or town) <i>Bethesda</i> (County) <i>Monty</i> (State) <i>Md</i>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <i>6-5-55</i>	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <i>Self inflicted gm. shot</i>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
SIGNATURE <i>Frank J. Brosehart</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <i>6-7-55</i> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL, (Specify): <i>Buried</i>		DATE THEREOF <i>6/10/55</i>		NAME OF CEMETERY OR CREMATORY <i>Parkland</i>	
DATE REC'D BY LOCAL REG. <i>6/7/55</i>		REGISTRAR'S SIGNATURE <i>Bessie M. Thompson</i>		24. FUNERAL DIRECTOR <i>Robert A. Mattingly</i> ADDRESS <i>131-11 St SE Wash D.C.</i>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6578

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BUREAU V. 2

JUN 9 1955

RECEIVED

Director, FBI

June 9, 1955

Mr. Tolson

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05718

5734

CERTIFICATE OF DEATH

Reg. Dist. No. 217.....

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Montgomery</u>			
X CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) <u>Olney</u>		LENGTH OF STAY (in this place) <u>40 min.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Silver Spring</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Montgomery County General Hospital, Inc.</u>				STREET ADDRESS (If rural give location) <u>Route 2</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>(Baby Girl) Dorsey</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>June 14 19 55</u>			
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Single</u>	8. DATE OF BIRTH: <u>6/14/55</u>	9. AGE last birthday <u>yr.</u>	IF UNDER 1 YEAR Months <u>Days</u>	IF UNDER 24 HRS. Hours <u>Min.</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Newborn</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Clifton Edward Dorsey</u>				14. MOTHER'S MAIDEN NAME: <u>Delores Toliver</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Hospital Record</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>762.5 Prolapsed</u>							<u>1 hour</u>
ANTECEDENT CAUSE (B) <u>Dumplings 5 1/2 mos</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Atelectasis</u>							<u>3 hours</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>C</u>		19B. MAJOR FINDINGS OF OPERATION: <u>-</u>					20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>6/14/55 7:30 AM</u>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR? <u>-</u>			
22. I hereby certify that I attended the deceased from <u>6/14/55</u> , 19 <u>55</u> , to <u>6/14/55</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>6/14/55</u> , 19 <u>55</u> , and that death occurred at <u>7:30 AM</u> from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>		M. D. <u>[Signature]</u>		DATE SIGNED <u>6/15/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>June 15/55</u>		NAME OF CEMETERY OR CREMATORY <u>Hotel</u>		LOCATION (City, town, or county) (State) <u>Rockville and</u>	
DATE REC'D BY LOCAL REGISTRAR <u>6-15-55</u>		REGISTRAR'S SIGNATURE <u>Estimate B Lawler</u>		24. FUNERAL DIRECTOR <u>Robert A. Snowden</u>		ADDRESS <u>Rockville</u>	

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RECEIVED

JUN 20 1955

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

05719

5735

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

Maryland

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Montgomery</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
TOWN <u>Bethesda</u>		TOWN <u>Bethesda</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>4617 East West Highway</u>		STREET ADDRESS (If rural give location) <u>4617 East West Hgy.</u>	
3. NAME OF DECEASED (First) <u>Adeline</u> (Middle) <u>Catherine Esqy</u> (Last) <u>Dunn</u>		4. DATE OF DEATH (Month) <u>June</u> (Day) <u>17</u> (Year) <u>1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widow</u>	8. DATE OF BIRTH <u>4 Jan. 1892</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>63</u> yrs. <u>5</u> months <u>13</u> days
13. FATHER'S NAME <u>Ferdinand Esqy</u>		11. BIRTHPLACE (State or foreign country) <u>Washington DC</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If year, give war or dates of service)		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
16. SOCIAL SECURITY NO. <u>none</u>		14. MOTHER'S MAIDEN NAME <u>Adeline Catherine Ayton</u>	
17. INFORMANT <u>William C. Pennington</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

18. MEDICAL CERTIFICATION

Immediate cause (a) Multiple Myeloma

Antecedent cause(s) (b) Arteriosclerotic Heart Disease

INTERVAL BETWEEN ONSET AND DEATH

1 YEAR

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

5 YEARS

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not White At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Dec. 7, 1954, to June 17, 1955, that I last saw the deceased alive on June 17, 1955, and that death occurred at 9:11 P.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>6-20-55</u>	<u>Rock Creek Cem.</u>	<u>Washington</u>	<u>D. C.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>6/18/55</u>	<u>Bessie M. Thompson</u>	<u>Robert A. Humphrey</u>	<u>Bethesda, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 21 1955

BUREAU V. S.

5736

CERTIFICATE OF DEATH

Reg. Dist. No. 215.....

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Montgomery		MARYLAND		STATE District of Columbia			
CITY (If outside corporate limits, write RURAL or and give nearest town) Bethesda Rural		LENGTH OF STAY (in this place) 16 days		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington, D.C. 47X-3			
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Naval Hospital				STREET ADDRESS (If rural give location) 515 16th Street, S.E. ✓			
3. NAME OF DECEASED: (First) (Middle) (Last) Leonard (n) EINHORN				4. DATE (Month) (Day) (Year) OF DEATH: June 18 19 55			
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: 5-22-15	9. AGE last birthday 40 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Eastman Kodak		10B. KIND OF BUSINESS OR INDUSTRY: Photography		11. BIRTHPLACE (State or foreign country): New York		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME: Harry EINHORN				14. MOTHER'S MAIDEN NAME: Katie LANZ			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give year or dates of service) Yes WW II		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT & ADDRESS: Wife Mrs. Irene F. EINHORN Same as above			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Infarction of liver, partial				3 day			
ANTECEDENT CAUSE (S) (B) Portal vein thrombosis				2 wks			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) Metastatic Adenocarcinoma of liver				16 wks			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Carcinoma Colon				18 wks			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 2 June , 19 55 , to 18 June , 19 55 , that I last saw the deceased alive on 18 June , 19 55 , and that death occurred at 6:05 AM , from the causes and on the date stated above.							
SIGNATURE C. Davis				ADDRESS		DATE SIGNED	
C. DAVIS LT MC USN U. S. Naval Hospital, WMC, Bethesda, Maryland							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		21 June 1955		Arlington National Cemetery		Arlington, Virginia	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
18 June 1955		Mary E. Ganssely		Danzansky & Son		3501 14th Street, N.W. Washington, D.C.	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 24 1955

BUREAU V. S.

5689

CERTIFICATE OF DEATH

Reg. Dist. No. 213

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Virginia</u>	COUNTY
CITY (If outside corporate limits, write and give nearest town) <u>17 TOWN Alabama Park 12 md</u>	RURAL LENGTH OF STAY (in this place) <u>7 days</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>OR TOWN Arlington</u>	<u>83X-3</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>75 Wash. San + Hospital</u>		STREET ADDRESS (If rural give location) <u>3602 Columbia P. ke</u>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <u>Hyman</u>	(Middle)	(Last) <u>Eller</u>	DATE OF DEATH: <u>6</u> <u>8</u> <u>1955</u>
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>Wh.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>7-20-80</u>
9. AGE last birthday <u>74</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Retired Merchant</u>		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>Russian</u>	
13. FATHER'S NAME: <u>Abraham Eller</u>		14. MOTHER'S MAIDEN NAME: <u>unknown.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>None</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: <u>Son of Hosp. Records</u>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE <u>157X</u>		<u>1 week</u>	
ANTECEDENT CAUSE (S)		<u>?</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		<u>?</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>May 13, 1955</u> , to <u>June 8, 1955</u> , that I last saw the deceased alive on <u>June 8, 1955</u> , and that death occurred at <u>8:38 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>[Signature]</u>		ADDRESS <u>6727-14th St. NW</u>	
DATE SIGNED <u>6-8-55</u>		M. D. <u>6727-14th St. NW</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	
<u>Burial</u>		<u>6-9-55</u>	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Wm T. Lehman Bmt</u>		<u>St. George, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		24. FUNERAL DIRECTOR	
<u>JUNE 8-1955</u>		<u>3501-14th St. NW</u>	
REGISTRAR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>Wash DC</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUN 10 1965

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5737

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05722

Reg. Dist.

No. 214

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Montg</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Rural - Silver Spring Rt. 2</u>		LENGTH OF STAY (in this place) <u>3 hrs</u>		CITY (If outside corporate limits write RURAL and give nearest town) <u>Silver Spring (rural)</u>			
TOWN <u>Silver Spring</u>				TOWN <u>Silver Spring</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Fairland Cedarcroft San. + Hosp</u>				STREET ADDRESS (If rural, give location) <u>Rt. 2</u>			
3. NAME OF DECEASED: (First) <u>Howard</u> (Middle) <u>C</u> (Last) <u>Fawcett</u>				4. DATE OF DEATH (Month) <u>June</u> (Day) <u>7</u> (Year) <u>1955</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>Sept. 5, 1870</u>		9. AGE last birthday: <u>84</u> yrs. <u>9</u> months <u>2</u> days		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Self Employed - Owner</u>		11. BIRTHPLACE (State or foreign country): <u>Montgomery Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Harvey C. Fawcett</u>				14. MOTHER'S MAIDEN NAME: <u>Marian Offutt</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <u>None</u>		17. INFORMANT & ADDRESS: <u>RFD #2 Evelyn Fawcett - Silver Spring, Md.</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
<u>420.1</u> Immediate cause (a) <u>Coronary occlusion</u> DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)							<u>Dead in bed</u>
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>. SIGNATURE <u>Frank J. Brochant</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>6-7-55</u> M. D. <u>Robert R. Humphrey</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>							
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>6-9-1955</u>		NAME OF CEMETERY OR CREMATORY <u>Rockville Union</u>		LOCATION (City, town, or county) (State) <u>Rockville, Montg Md</u>	
DATE REC'D BY LOCAL REG. <u>6-9-55</u>		REGISTRAR'S SIGNATURE <u>Frances Voller</u>		24. FUNERAL DIRECTOR <u>Robert R. Humphrey</u> ADDRESS <u>Bethesda, Md.</u>			

BUREAU V. 8

JUN 13 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5738
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05723
Reg. Dist.

No. 214

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Montg</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR			
TOWN <u>Kensington</u>		<u>2 1/2 yrs</u>		TOWN <u>Kensington</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>9908 Cedar Lane</u>				STREET ADDRESS (If rural, give location) <u>9908 Cedar Lane</u>			
3. NAME OF DECEASED: (Type or Print)		(First) <u>Agnes</u>		(Middle) <u>Isabell</u>		(Last) <u>Fleischman</u>	
5. SEX: <u>Fe</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>		8. DATE OF BIRTH: <u>11-6-1871</u>	
				9. AGE last birthday: <u>83</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>-</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>James E. Topper</u>				14. MOTHER'S MAIDEN NAME: <u>Samar Fern M. de Shazo (daughters) Stem 2</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		(If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>Samar Fern M. de Shazo (daughters) Stem 2</u>	

18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			INTERVAL BETWEEN ONSET AND DEATH <u>Some days in bed</u>
Immediate cause (a) <u>Coronary occlusion</u> DUE TO			
Antecedent cause(s) (b) <u>Diseases or conditions, if any, giving rise to the above cause stating underlying cause last</u> DUE TO			
(c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <u>Frank J. Broerhant</u>		M. D. ASSISTANT MEDICAL EXAM. <u>6-11-55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>6-11-55</u>	
NAME OF CEMETERY OR CREMATORY <u>Pt. Lincoln</u>		LOCATION (City, town, or county) (State) <u>Bladensburg Rd., Md.</u>	
DATE REC'D BY LOCAL REG <u>6-14-55</u>		REGISTRAR'S SIGNATURE <u>Francis J. Broerhant</u>	
24. FUNERAL DIRECTOR		ADDRESS <u>5732 Ed Lane NE</u>	

BUREAU V. S.

JUN 16 1955

RECEIVED

5739

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Montgomery</u>
CITY (If outside corporate limits, write and give nearest town) <u>Bethesda</u>	RURAL	CITY (If outside corporate limits, write and give nearest town) <u>Cherry Chase</u>	RURAL <u>X</u>
TOWN	LENGTH OF STAY (in this place) <u>6-12-55 to 6-16-55</u>	TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban</u>		STREET ADDRESS (If rural give location) <u>4200 Romaine St.</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>Margaret Core Fleming</u>		<u>June 16 1955</u>	
5. SEX: <u>F.</u>	6. COLOR OR RACE: <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>W</u>	8. DATE OF BIRTH: <u>6/1/89</u>
9. AGE last birthday <u>65</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY: <u>U.S.</u>	
13. FATHER'S NAME: <u>Rev. Andrew Fleming</u>		14. MOTHER'S MAIDEN NAME: <u>Elizabeth Primer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT & ADDRESS: <u>Margaret C. Fleming, Cherry Chase, Md.</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
442X IMMEDIATE CAUSE			
ANTECEDENT CAUSE (S)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(A) <u>acute congestive heart failure 4 days</u>			
DUE TO			
(B) <u>Cardio-vascular renal disease 3 yrs</u>			
DUE TO			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>June 12, 1955</u> , to <u>June 16, 1955</u> , that I last saw the deceased alive on <u>June 15, 1955</u> , and that death occurred at <u>7:35 AM</u> , from the causes and on the date stated above.			
SIGNATURE <u>Sidney G. Bouscous</u>		DATE SIGNED <u>6/16/55</u>	
ADDRESS <u>M. D. 3921 Ingomar Ave. Wash. D.C.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>		DATE THEREOF <u>6-16-55</u>	
NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		LOCATION (City, town, or county) <u>Suitland, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>6/18/55</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	
24. FUNERAL DIRECTOR <u>Robert Thompson</u>		ADDRESS <u>Bethesda, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

JUN 21 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5740

CERTIFICATE OF DEATH

Reg. Dist. No. 05725 216

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u> MARYLAND		STATE <u>Maryland</u> COUNTY <u>--</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bethesda</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Old Fort Rd. (22)</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>142 days</u>		STREET ADDRESS (If rural give location) <u>9135 Old Fort Rd.</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Mary Elizabeth Flemings</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>June 21 1955</u>	
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Separated</u>	8. DATE OF BIRTH: <u>26 Jan. 1901</u>
9. AGE last birthday <u>54</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Domestic</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>--</u>	11. BIRTHPLACE (State or foreign country): <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME: <u>Peter Short</u>	
14. MOTHER'S MAIDEN NAME: <u>--</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>No</u> (If Yes, give war or dates of service) <u>--</u>	
16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS: <u>The Medical Record, The Clinical Center</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Cancer of cervix with widespread metastases</u>			
ANTECEDENT CAUSE (S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>3 2/21/55</u>		19B. MAJOR FINDINGS OF OPERATION: <u>Ca. of cervix</u>	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>--</u>	21C. WHERE DID (City or town) INJURY OCCUR? <u>--</u>	(County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>--</u> M.	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21F. HOW DID INJURY OCCUR? <u>--</u>	
22. I hereby certify that I attended the deceased from <u>31 Jan. 1955</u> , to <u>21 June 1955</u> , that I last saw the deceased alive on <u>21 June 1955</u> , and that death occurred at <u>7:00A M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Donald N. Cohen</u>		DATE SIGNED <u>The Clinical Center</u> M. D. Nat'l Institutes of Health	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>June 25-55</u>	DATE THEREOF	NAME OF CEMETERY OR CREMATORY <u>Church Cemetery</u>	LOCATION (City, town, or county) (State) <u>Chapel Hill Md. Po. So. Co.</u>
DATE REC'D BY LOCAL REGISTRAR <u>6/24/55</u>	REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	24. FUNERAL DIRECTOR <u>John T. Shivers & Co.</u>	ADDRESS <u>901-3rd St. S.W. DC</u>

BUREAU V. S.

JUN 27 1955

RECEIVED

5741

CERTIFICATE OF DEATH

Reg. Dist. No. 2, 8

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Montgomery</i>	MARYLAND	STATE <i>md</i>	COUNTY <i>Montgomery</i>
CITY (If outside corporate limits, write name of nearest town) <i>Northsburg</i>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write name of nearest town) <i>Northsburg</i>	OR TOWN <i>Northsburg</i>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>18</i>		STREET ADDRESS (If rural give location) <i>1</i>	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <i>Basil</i>	(Middle) <i>Ray</i>	(Last) <i>Frazier</i>	(Month) <i>6</i> (Day) <i>28</i> (Year) <i>1955</i>
5. SEX: <i>Male</i>	6. COLOR OR RACE: <i>Negro</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Married</i>	8. DATE OF BIRTH: <i>1882</i>
9. AGE last birthday: <i>73</i> yrs. <i>mo</i> <i>9</i> days		10. AGE UNDER 1 YEAR: <i>9</i> months <i>9</i> days	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House mover</i>		12. KIND OF BUSINESS OR INDUSTRY: <i>House mover</i>	
13. BIRTHPLACE (State or foreign country): <i>Northsburg, Md</i>		14. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
15. FATHER'S NAME: <i>Basil J. Frazier</i>		16. MOTHER'S MAIDEN NAME: <i>Wilson</i>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service)		18. SOCIAL SECURITY NO.	
		19. INFORMANT & ADDRESS: <i>Patience E. Frazier - Northsburg, Md</i>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) <i>Inanition and Malnutrition</i>		<i>30 to 60 days</i>
ANTECEDENT CAUSE (S) DUE TO		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		
(B) DUE TO		
(C) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION: <i>None</i>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
-------------------------------------	----------------------------------	--

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOT BY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *6/26*, 19*55*, to *6/27*, 19*55*, that I last saw the deceased alive on *6/27*, 19*55*, and that death occurred at *6:25 A*, from the causes and on the date stated above.

SIGNATURE <i>Damascus, Md</i>	ADDRESS <i>M. P. Mason Co</i>	DATE SIGNED <i>6/28/55</i>
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	DATE THEREOF <i>July 1, 1955</i>	NAME OF CEMETERY OR CREMATORY <i>Brooke Grove</i>
LOCATION (City, town, or county) <i>Laytonville, Md</i>	(State) <i>Md</i>	
DATE REC'D BY LOCAL REGISTRAR <i>July 1, 1955</i>	REGISTRAR'S SIGNATURE <i>Abner G. Cook</i>	24. FUNERAL DIRECTOR <i>Robert L. Swarden - Rockville, Md</i>

MARGIN RESERVED FOR BINDING

BUREAU V. S.

MIL 8 1955

RECEIVED

5742

05727

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 216

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Montgomery	MARYLAND	STATE	COUNTY
CITY (If outside corporate limits, write RURAL or and give nearest town) TOWN Rural Glen Echo	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) TOWN Washington, D.C.	47X-3
HOSPITAL OR INSTITUTION OR STREET ADDRESS Potomac River at Sycamore		STREET ADDRESS (If rural, give location) 2424 Chain Bridge Rd. N.W.	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) Donald	(Middle) Preston	(Last) Frizzell	(Month) June (Day) 7 (Year) 1955
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, Single	8. DATE OF BIRTH: Nov. 19, 1935
9. AGE last birthday: 19 yrs.		10. BIRTHPLACE (State or foreign country): Washington, D.C.	
11. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): None		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Richard Frizzell		14. MOTHER'S MAIDEN NAME: Bessie Clark	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: None	
17. INFORMANT & ADDRESS: Bessie Clark Item 2			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
<p>929.8 Immediate cause (a) Asphyxia DUE TO</p> <p>Antecedent cause(s) (b) drowning DUE TO</p> <p>Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)</p>		
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY near Glen Echo	21c. (City or town) (County) (State) Monty 15 md
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY 6-7-55 9:30 P.M.	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? drowned while swimming
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		
SIGNATURE Frank J. Broschart		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 6-8-55
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAM. <input type="checkbox"/>
23. BURIAL, CREMATION, REMOVAL (Specify): Burial	DATE THEREOF 6-10-55	NAME OF CEMETERY OR CREMATORY Methodist Cem.
LOCATION (City, town, or county) (State) Potomac Md.		
DATE REC'D BY LOCAL REG. 6/8/55	REGISTRAR'S SIGNATURE Bessie M. Thompson	24. FUNERAL DIRECTOR W. W. Chambers & Co. 1400-Chain Bridge Rd. N.W.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5712

1. (unintelligible)

Hotel, Glen Echo

1. (unintelligible) as by name

1. (unintelligible)

1. (unintelligible) as by name

1. (unintelligible)

1. (unintelligible)

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1. (unintelligible)

BUREAU V. 2

JUN 13 1955

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Montgomery		MARYLAND		STATE Maryland		COUNTY Mont.	
CITY (If outside corporate limits, write RURAL OR and give nearest town) Laurel		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) Laurel			
HOSPITAL OR INSTITUTION OR STREET ADDRESS McKnew Road				STREET ADDRESS (If rural give location) McKnew Road			
3. NAME OF DECEASED: (First) Arthur (Middle) James (Last) Fulton				4. DATE OF DEATH: (Month) June (Day) 12 (Year) 1955			
5. SEX: M	6. COLOR OR RACE: W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: May 29, 1879	9. AGE last birthday: 76 yrs.	IF UNDER 1 YEAR: Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: Supervisor		10b. KIND OF BUSINESS OR INDUSTRY: Race Track Mutuel Dept		11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Arthur Fulton				14. MOTHER'S MAIDEN NAME: Angeline Taylor			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY No.: 218-03-2855		17. INFORMANT & ADDRESS: Mrs. Thelma E. Fulton, Laurel, Maryland			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				Interval Between Onset And Death			
592X Immediate cause (a) Uremia				3 da			
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Chronic Intestinal Nephritis							
(c) Hypertension - Initial Diagnosis							
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 3/11 , 19 53 , to 6/12 , 19 53 , that I last saw the deceased alive on 6/12 , 19 53 , and that death occurred at 2p , from the causes and on the date stated above. SIGNATURE (Degree or title) Dr. B. J. [Signature] ADDRESS 314 Comp. Ave. Laurel 4/12/53 DATE SIGNED							
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		June 15, 1955		Union Cemetery		Burtonsville, Maryland	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
June 15 - 55		[Signature]		[Signature]		[Address]	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUN 20 1955

RECEIVED

5710

CERTIFICATE OF DEATH

Reg. Dist. No. 213

1. PLACE OF DEATH:

COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) Rockville
TOWN RockvilleHOSPITAL OR
INSTITUTION OR
STREET ADDRESS 807 Grandin Ave,

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) Rockville
OR
TOWN RockvilleSTREET
ADDRESS (If rural give location)
807 Grandin Ave.3. NAME OF DECEASED: (First) (Middle) (Last)
(Type or Print) EDWARD (NMI) GANDY4. DATE (Month) (Day) (Year)
OF DEATH: June 23, 19555. SEX: Male 6. COLOR OR RACE: White 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married8. DATE OF BIRTH: 9-1-18699. AGE last birthday 85 yrs. IF UNDER 1 YEAR: Months 9 Days 22 Hours Min. 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter10B. KIND OF BUSINESS OR INDUSTRY: Self Emp.11. BIRTHPLACE (State or foreign country): England12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME:

Unknown

14. MOTHER'S MAIDEN NAME:

Unknown15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No16. SOCIAL SECURITY NO. None17. INFORMANT & ADDRESS: Virginia Dorsey-Item# 2

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

450.0

IMMEDIATE CAUSE

(A) Cardio-respiratory failure

INTERVAL BETWEEN ONSET AND DEATH

30 min

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(B) Generalized arteriosclerosisIndef.

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID (City or town) (County) (State)
INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED While ☐ Not while ☐ at work at work

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/3/1953, to 6/23/1953, that I last saw the deceased alive on 6/23/1955, and that death occurred at 11:15 PM, from the causes and on the date stated above.

SIGNATURE

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (SPECIFY)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county) (State)

Burial6-27-55Rockville UnionRockville, Md.

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

6/28/55Laurel H. GraysonRobert L. HumphreyBethesda, Md.

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 29 1955

BUREAU V. S.

5744

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY	Montgomery		MARYLAND	STATE	Maryland
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)	COUNTY	Howard
X TOWN	19 days		OR TOWN	Simpsonville	13x-2
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Montgomery County General Hospital, Inc.		STREET ADDRESS	(If rural give location)	
3. NAME OF DECEASED:			4. DATE OF DEATH:		
(First)	(Middle)	(Last)	(Month)	(Day)	(Year)
(Type or Print)	John	Theodore	Gibson	June	24 19 55
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR
Male	Colored	Single		48?	Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):			10B. KIND OF BUSINESS OR INDUSTRY:		
Laborer			Farm		
11. BIRTHPLACE (State or foreign country):			12. CITIZEN OF WHAT COUNTRY?		
Maryland			U.S.A.		
13. FATHER'S NAME:			14. MOTHER'S MAIDEN NAME:		
Charles Gibson			Mary Rogers		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY No.		
			17. INFORMANT & ADDRESS:		
			Hospital Record		

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
019.2		
IMMEDIATE CAUSE	(A) Miliary Tuberculosis	6 months
ANTECEDENT CAUSE (S)	DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	(B) DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
Hemolytic staphylococcus septicemia		3 weeks

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5/28/55, 19....., to 6/24/55, 19....., that I last saw the deceased alive on 6/24/55, 19....., and that death occurred at 8:17 M, from the causes and on the date stated above.

SIGNATURE	ADDRESS	DATE SIGNED
Charles S. Whitaker,	M. D. Clarksville, Md.	6/24/55
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY
Burial	6/28/55	Methodist Church Cemetery
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS
6-29-55	Esther B. Lawler	F.C. Higinbotham Ellicott City, Md.

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU Y. M.

JUL 5 1955

RECEIVED

5690

05731
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 213

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>montg</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN <u>Takoma Park</u>		<u>14 yrs</u>		TOWN <u>Takoma Park</u>		<u>17</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7216 Willow Ave</u>				STREET ADDRESS (If rural, give location) <u>7216 Willow Ave</u>			
3. NAME OF DECEASED: (First) <u>Mary</u>		(Middle) <u>Joane Todd</u>		(Last) <u>Gibson</u>		4. DATE OF DEATH (Month) <u>June</u> (Day) <u>9</u> (Year) <u>1955</u>	
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>		8. DATE OF BIRTH: <u>6-18-1870</u>	
9. AGE last birthday: <u>84</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>house work</u>		11. BIRTHPLACE (State or foreign country): <u>Arkansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Willis H. Todd</u>				14. MOTHER'S MAIDEN NAME: <u>Caroline E. Chester</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>Sam. or Caroline G. Berry (daughter) Ste 2</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause (a) <u>Cornary occlusion</u>						<u>42 hrs.</u>	
DUE TO							
Antecedent cause(s) (b) <u>Diseases or conditions, if any, giving rise to the above cause</u>							
DUE TO							
stating underlying cause last (c) <u></u>							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Frank J. Brozant</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>6-9-55</u>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
				M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>6-11-55</u>		NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cem.</u>		LOCATION (City, town, or county) (State) <u>Wash. D.C.</u>	
DATE REC'D BY LOCAL REG. <u>JUNE 9-1955</u>		REGISTRAR'S SIGNATURE <u>J. Wilson Todd</u>		24. FUNERAL DIRECTOR <u>S.H. Hines Co.</u>		ADDRESS <u>2901 14th N.W. Wash. D.C.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 10 1955

BUREAU V. S.

5691

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Montgomery</i>	MARYLAND	STATE <i>Pa.</i>	COUNTY <i>83x3</i>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Takoma Park</i>	LENGTH OF STAY (in this place) <i>13 days</i>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Portsmouth, Va.</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Washington Sanitarium Hospital</i>		STREET ADDRESS (If rural give location) <i>213 Grayson St.</i>	✓
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <i>Harry</i>	(Middle) <i>Isaac</i>	(Last) <i>Glazer</i>	DATE OF DEATH: <i>6 - 12 - 19 55</i>
5. SEX: <i>M</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH: <i>7-16-84</i>
		9. AGE last birthday <i>70</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Merchant</i>		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <i>Lithuania</i>
13. FATHER'S NAME: <i>Meyer Glazer</i>		14. MOTHER'S MAIDEN NAME: <i>Bailey</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, of unk.) (If yes, give war or dates of service) <i>no</i>		17. INFORMANT & ADDRESS: <i>Washington Sanitarium Hospital Records</i>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <i>Acute myocardial failure</i>			<i>8h</i>
ANTECEDENT CAUSE (S) DUE TO (B) <i>Coronary occlusion</i>			<i>14h</i>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <i>260x</i> (C) <i>Arteriosclerotic Heart Disease</i>			<i>5 years</i>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Diabetes mellitus</i>			<i>5 years</i>
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21F. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <i>June 1955</i> , to <i>12 June 1955</i> that I last saw the deceased alive on <i>12 June 1955</i> , and that death occurred at <i>11:30 AM</i> , from the causes and on the date stated above.			
SIGNATURE <i>Russell B. Arnold</i>		DATE SIGNED <i>12 June 55</i>	
ADDRESS <i>M. D. 8801 Coleridge Rd., S.S. Md.</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Transit Burial</i>		DATE THEREOF <i>6-14-55</i>	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State) <i>Portsmouth, Va.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>June 12 1955</i>		24. FUNERAL DIRECTOR ADDRESS <i>J. Arthur Walter, 254 Carroll St., N.W., Wash. D.C.</i>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 15 1955
BUREAU V. S.

5745

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		LENGTH OF STAY (In this place) <u>15 min</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		<u>26</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban</u>				STREET ADDRESS (If rural give location) <u>525 West Montgomery Ave</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Everett Stratmeyer Gornley</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>June 12 1955</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>widow</u>		8. DATE OF BIRTH: <u>Feb. 16, 1904</u>	
				9. AGE last birthday: <u>5-1</u> yrs.		IF UNDER 1 YEAR: Months <u>3</u> Days <u>26</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Supervisor of Materials School</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME: <u>Harry E. Stratmeyer</u>				14. MOTHER'S MAIDEN NAME: <u>Charlotte Davis</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Mrs. Charlotte Stratmeyer 525 West Montgomery Ave. Rockville, Md.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE (A) <u>acute Coronary Thrombosis</u>						8 hrs.	
ANTECEDENT CAUSE (S) DUE TO (B) <u>atherosclerosis of Left Descending</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <u>Branch of coronary artery.</u>							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April</u> , 1953 to <u>JUNE 12, 1955</u> that I last saw the deceased alive on <u>JUNE 12, 1955</u> , and that death occurred at <u>4:45 P.M.</u> from the causes and on the date, stated above.							
SIGNATURE <u>William Frank</u>				ADDRESS <u>M. D. 1014 VIERS MILL RD.</u>		DATE SIGNED <u>6/13/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town or county) (State)	
		<u>6/16/55</u>		<u>Parklawn</u>		<u>Rockville, Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>6/14/55</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		24. FUNERAL DIRECTOR <u>Robert L. Humphrey</u>		ADDRESS <u>Bethesda, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUN 16 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05734

5692

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>md.</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
<u>17 TOWN Takoma Park, Maryland</u>		<u>22 hrs.</u>		<u>17</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>75 Washington Sanitarium & Hospital 6607 9th & 10th Aves. Takoma Park, Md.</u>				<u>1</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>Emma Frances Green</u>				<u>June 30 1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Female</u>	<u>White</u>	<u>Married</u>	<u>10-26-1899</u>	<u>55</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<u>Housewife</u>				<u>at home</u>		<u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY?				<u>U.S.A.</u>			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>George W. Tyler</u>				<u>Rose Norton</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
<u>no</u>				<u>none</u>			
17. INFORMANT & ADDRESS:				<u>Patient's chart</u>			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A)				INTERVAL BETWEEN ONSET AND DEATH			
<u>331X Intracranial hemorrhage</u>				<u>1 day</u>			
ANTECEDENT CAUSE (B)				DUE TO			
<u>Essential hypertension</u>				<u>15 yrs.</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
<u>2nd degree burn left face & arm</u>				<u>1 day</u>			
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6-1</u> , 19 <u>54</u> , to <u>6-30</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>6-30</u> , 19 <u>55</u> , and that death occurred at <u>8:30 PM</u> , from the causes and on the date stated above.							
SIGNATURE				ADDRESS		DATE SIGNED	
<u>Samuel M. Bazant</u>				<u>M. D. Wash. D.C.</u>		<u>7-1-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>7/5/1955</u>		<u>Rock Creek Cemetery</u>		<u>Wash., D.C.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>July 1-1955</u>		<u>J. W. Dodds</u>		<u>W. W. Chambers Co.</u>		<u>1400 CHAMBERS</u>	

BUREAU V. B.

JUL 5 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5746

05735

Reg. Dist. No. 215

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Virginia</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR			
X TOWN <u>Bethesda R ural</u>		<u>20 A.</u>		TOWN <u>Alexandria</u> <u>83 X - 3</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Naval Hospital</u>				STREET ADDRESS (If rural, give location) <u>15 East Bellefont</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print) <u>Raymond</u> (n) <u>GRIFFITH</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>June 21 19 55</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>11-5-98</u>	9. AGE last birthday: <u>56</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>U. S. Government</u>		11. BIRTHPLACE (State or foreign country): <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME: <u>Unknown</u>				14. MOTHER'S MAIDEN NAME: <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes</u> <u>WW I</u>		16. SOCIAL SECURITY No.: <u>Unknown</u>		17. INFORMANT & ADDRESS: <u>Wife Mrs. Mabel GRIFFITH</u> <u>Same as above</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						18. MEDICAL CERTIFICATION	
<u>331X</u> Immediate cause (a) <u>Cerebral Hemorrhage</u> DUE TO						INTERVAL BETWEEN ONSET AND DEATH <u>7</u>	
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.							
SIGNATURE <u>John L. Stiers</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAM. <input checked="" type="checkbox"/> <u>6-22-55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>24 June 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Ivy Hill Cemetery</u>		LOCATION (City, town, or county) (State) <u>Alexandria, Virginia</u>	
DATE REC'D BY LOCAL REG. <u>22 June 1955</u>		REGISTRAR'S SIGNATURE <u>Mary E. Parrelly</u>		24. FUNERAL DIRECTOR <u>Wheatley Funeral Home</u>		ADDRESS <u>809 King Street, Alexandria, Virginia</u>	

BUREAU V. S.

JUN 24 1955

RECEIVED

5747

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A155

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Bethesda</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>	
TOWN <u>Bethesda</u>		TOWN <u>Cherry Chase</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>RESMOR SANITARIUM</u>		STREET ADDRESS <u>5203 Andover Road</u>	
3. NAME OF DECEASED (First) <u>JOHN</u> (Middle) <u>ADAMS</u> (Last) <u>GROSE</u>		4. DATE OF DEATH (Month) <u>6</u> (Day) <u>18</u> (Year) <u>1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>3 AUG. 1870</u>
9. AGE last birthday <u>84</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Methodist Minister</u>	
11. BIRTHPLACE (State or foreign country) <u>Cumberland Ind.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Adams Grose</u>		14. MOTHER'S MAIDEN NAME <u>Melissa Dickens</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If year, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT AND ADDRESS <u>Miss Margaret Armiger Silver Spring Maryland</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH										18. SIGNATURE OF PHYSICIAN		19. INTERVAL BETWEEN ONSET AND DEATH			
Immediate cause (a) <u>Respiratory Failure</u>												<u>24 hrs.</u>			
Antecedent cause(s) (b) <u>Heart Failure</u>												<u>3 days</u>			
Diseases or conditions, if any, giving rise to the above cause stating the <u>underlying cause last</u> (c) <u>Adenocarcinoma of Colon</u>												<u>6 mo.</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Advanced Arteriosclerosis</u>												<u>2 years</u>			
19a. DATE OF OPERATION					19b. MAJOR FINDINGS OF OPERATION					20. AUTOPSY?					
										Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					
21. ACCIDENT SUICIDE HOMICIDE			(Specify)			PLACE (Home, farm, factory, street, OF office bldg., etc.)			(CITY OR TOWN)			(COUNTY)		(STATE)	
TIME (Month) (Day) (Year)			(Hour)			INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>			HOW DID INJURY OCCUR?						
OF INJURY			m.												

22. I hereby certify that I attended the deceased from 3/20, 1955, to 6/8, 1955, that I last saw the deceased alive on 6/7, 1955, and that death occurred at 3 A.m., from the causes and on the date stated above.

SIGNATURE _____ (Degree or title) ADDRESS _____ DATE SIGNED _____

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<i>cremation</i>	<i>June 10 / 1955</i>	<i>Shepherdstown</i>	<i>Shepherdstown West Virginia</i>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<i>June 10, 1955</i>	<i>Bessie M. Thornybaun</i>	<i>Roy W Barber</i>	<i>Laytonsville, Maryland</i>	

BUREAU V. S.

JUN 13 1955

RECEIVED

5748

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>md.</u>	COUNTY <u>Montgomery</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Bethesda</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rockville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>suburban</u>		STREET ADDRESS (If rural give location) <u>Rt #2</u>	
3. NAME OF DECEASED: (Type or Print)	(First) <u>Baby</u> (Middle) <u>Boy</u> (Last) <u>Hall</u>	4. DATE (Month) (Day) (Year) OF DEATH: <u>June 8 1955</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>negr</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):	8. DATE OF BIRTH: <u>June 8/55</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	9. AGE last birthday: <u>7</u> yrs. Months Days Hours Min.
11. BIRTHPLACE (State or foreign country): <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Jackie Redgwick</u>		14. MOTHER'S MAIDEN NAME: <u>Anna Bell Hall</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: <u>Mother Rt #2 Rockville</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
762.5 IMMEDIATE CAUSE (A) <u>Asphyxia</u>		<u>7 hours 20 min.</u>
ANTECEDENT CAUSE (S) (B) <u>Immaturity (5 1/2 months)</u>		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Premature labor</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>June 8, 1955</u> , to <u>June 8, 1955</u> , that I last saw the deceased alive on <u>June 8, 1955</u> , and that death occurred at <u>9:05 A</u> M, from the causes and on the date stated above.					
SIGNATURE <u>William M. Thompson</u>		M. D.		DATE SIGNED <u>6/8/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Rural</u>		DATE THEREOF <u>6-11-55</u>		NAME OF CEMETERY OR CREMATORY <u>Lincoln Park</u>	
LOCATION (City, town, or county) (State) <u>Rockville, Md</u>		24. FUNERAL DIRECTOR		ADDRESS <u>Robert L. Snodden - Rockville</u>	
DATE REC'D BY LOCAL REGISTRAR <u>6/11/55</u>		REGISTRAR'S SIGNATURE <u>Bernie M. Thompson</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUN 13 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05738

5749

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Bethesda</u>		LENGTH OF STAY (in this place) <u>37 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Barnesville</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>Arthur Eugene Hallman</u>				<u>June 4 1955</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>col</u>		8. DATE OF BIRTH: <u>Sept. 5, 1880</u>		9. AGE last birthday <u>74</u> yrs.	
		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):				IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Truckman</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>B. & O. Railroad</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
13. FATHER'S NAME: <u>Moses Hallman</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Bertine Onley Barnesville, Md.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1							
IMMEDIATE CAUSE (A) <u>Acute myocardial infarction</u>						few minutes	
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>Coronary thrombosis, Rt. posterior</u>							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Pulmonary emboli, bilateral</u>							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>May 18, 1955</u> , to <u>June 4, 1955</u> , that I last saw the deceased alive on <u>June 4, 1955</u> and that death occurred at <u>12:15 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Genge Sharpe</u>				ADDRESS <u>M. D. 10647 Conn. Ave Kensington, Md</u>		DATE SIGNED <u>6-6-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial June 8, 55</u>				DATE THEREOF <u>June 8, 55</u>		NAME OF CEMETERY OR CREMATORY <u>Bellschapel</u>	
						LOCATION (City, town, or county) (State) <u>Dickinson Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>6/10/55</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		24. FUNERAL DIRECTOR <u>Robert L. Smucker</u>		ADDRESS <u>Rockville</u>	

RECEIVED

JUN 13 1955

BUREAU V. S.

5750

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Texas</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>San Antonio</u> <u>80X-3</u>			
X TOWN <u>Bethesda</u>				STREET ADDRESS (If rural give location) <u>140 Harriette Drive</u> ✓			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>The Clinical Center Natl. Institutes of Health</u>							
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH: <u>June 5 1955</u>			
<u>Elinor Ruth Hammer</u>							
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>October 12, 1902</u>	9. AGE last birthday <u>52</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>--</u>		11. BIRTHPLACE (State or foreign country): <u>Texas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Sam Harris</u>				14. MOTHER'S MAIDEN NAME: <u>Hannah Frank</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS: <u>The medical record, The Clinical Center</u>			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>190X Malignant melanoma</u>							
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>4/28/55</u>		19B. MAJOR FINDINGS OF OPERATION: <u>Malignant melanoma</u>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>--</u>		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? <u>--</u>			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>--</u> M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>--</u>			
22. I hereby certify that I attended the deceased from <u>April 2, 1955</u> , to <u>June 5, 1955</u> , that I last saw the deceased alive on <u>June 5, 1955</u> , and that death occurred at <u>11:00 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>R. Lane Carroll</u>		ADDRESS <u>The Clinical Center Natl. Institutes of Health</u>		DATE SIGNED <u>6/6/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>CREMATION</u>		DATE THEREOF <u>JUNE 6, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		LOCATION (City, town, or county) (State) <u>5417LAND, MD.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>6/6/55</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		24. FUNERAL DIRECTOR <u>Jos. Gawler's Son & Co.</u>		ADDRESS <u>1756 86 Ave</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 9 1955

BUREAU V. S.

5751

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>Montgomery</u> MARYLAND			STATE <u>W. Virginia</u> COUNTY <u>--</u>		
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Bethesda</u>			CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Summit Point, W. Virginia</u>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>The Clinical Center Nat'l Institutes of Health</u>			STREET ADDRESS (If rural give location) <u>--</u>		
3. NAME OF DECEASED: (First) (Middle) (Last)			4. DATE (Month) (Day) (Year) OF DEATH:		
<u>Rease -- Harris</u>			<u>June 17 1955</u>		
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR
<u>M</u>	<u>N</u>	<u>Married</u>	<u>17 March 1889</u>	<u>66</u> yrs.	Months <u>3</u> Days <u>0</u> Hours <u>0</u> Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?	
<u>Farmer</u>		<u>Farming</u>	<u>W. Virginia</u>	<u>USA</u>	
13. FATHER'S NAME:			14. MOTHER'S MAIDEN NAME:		
<u>-- Harris</u>			<u>Margaret Johnson</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS:		
<u>No</u>		<u>--</u>	<u>The Medical Record, The Clinical Center</u>		
18. MEDICAL CERTIFICATION					INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
IMMEDIATE CAUSE (A) <u>Carcinoma of lungs with metastasis</u>					
ANTECEDENT CAUSE (B) <u>DUE TO</u>					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>DUE TO</u>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
<u>June 10, 1955</u>		<u>Biopsy of skin nodule - metast. carcinoma.</u>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?		
		<u>none</u>			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
		<u>M.</u>			
22. I hereby certify that I attended the deceased from <u>10 Jan., 1955</u> , to <u>17 June, 1955</u> , that I last saw the deceased alive on <u>17 June, 1955</u> , and that death occurred at <u>9:00A</u> M, from the causes and on the date stated above.					
SIGNATURE <u>J. Leonard Gelf</u>		ADDRESS <u>The Clinical Center Nat'l Institutes of Health</u>		DATE SIGNED <u>17 June 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>	<u>6-20-55</u>	<u>Jamestown Cem</u>		<u>Jefferson Co. W. Virginia</u>	
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR		ADDRESS	
<u>6/18/55</u>	<u>Bessie M. Thompson</u>	<u>Melvin S. Strider</u>		<u>Charles Town, W. Va.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUN 21 1955

RECEIVED

5752

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>District of Columbia</u>		<u>47X3</u>	
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
<u>Bethesda Rural</u>		<u>65 days</u>		<u>Washington, D.C.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>U. S. Naval Hospital</u>				<u>1025 15th Street, N.W.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>Hobart Horace Hart</u>				<u>June 4 19 55</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>White</u>	<u>Single</u>	<u>9 January 1900</u>	<u>55 yrs.</u>	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<u>Clothing business</u>				<u>Clothing business</u>		<u>New York</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Wallace BURDETTE</u>				<u>K. N. NORMAND</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<u>Yes</u> <u>WW I</u>				<u>Unknown</u>		<u>Friend Hazel VARNEY</u> <u>1025 15th St. N.W., Washington, D.C.</u>	
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Carcinoma of Left Lung</u>							<u>Months</u>
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<u>Sept. 1954</u>				<u>Carcinoma of Lung (Left)</u>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>1 April, 19 55</u> to <u>4 June, 19 55</u> , that I last saw the deceased alive on <u>4 June, 19 55</u> , and that death occurred at <u>6:35 PM</u> , from the causes and on the date stated above.							
SIGNATURE				ADDRESS		DATE SIGNED	
<u>A. J. CAPPELLOTTI</u>				<u>LT MC USN U. S. Naval Hospital, Bethesda, Maryland</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Cremation</u>		<u>6-10-55</u>		<u>Lee's Modern Funeral Home</u>		<u>Washington, D. C.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>9 June 1955</u>		<u>Mary E. Cappelletti</u>		<u>Lee Funeral Home</u>		<u>4th & Mass. Ave. NE</u> <u>Washington, D. C.</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

EX-107



BUREAU V. S.

JUN 14 1955

RECEIVED

5753

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

COUNTY Montgomery

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town)

TOWN Bethesda

LENGTH OF STAY (in this place)

HOSPITAL OR

INSTITUTION OR

STREET ADDRESS Suburban Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Montgomery

CITY (If outside corporate limits, write RURAL and give nearest town)

OR TOWN Rockville

STREET ADDRESS (If rural, give location)

1003 Paul Drive

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

LOUISEA.HAYWARD

4. DATE OF DEATH:

(Month)

(Day)

(Year)

June 24,19 55

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH:

9. AGE last birthday:

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Female WhiteWidowed9-12-187183 yrs.Months 9 Days 12Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

HousewifeOwn HomeMarylandUS

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

Porter Alger? Brosius

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

NoRobert E. Learmouth- Item # 2

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

331X

Immediate cause

(a) Cerebro vascular accident

DUE TO

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) Generalized arteriosclerosis

DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH

4 hours20 years

II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 24, 1955, to June 24, 1955, that I last saw the deceased alive on June 24, 1955, and that death occurred at 9:25 a.m., from the causes and on the date stated above.

SIGNATURE

(DEGREE OR TITLE)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG. 6/27/55

REGISTRAR'S SIGNATURE

Parklawn

24. FUNERAL DIRECTOR

Bethesda, Maryland

ADDRESS

Bessie M. ThompsonRobert A. CampbellBethesda, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 1

JUN 30 1955

RECEIVED

5754

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Montgomery		MARYLAND		STATE District of Columbia			
CITY (If outside corporate limits, write RURAL and give nearest town) Bethesda Rural		LENGTH OF STAY (in this place) 22 days		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington, D.C. 47X-3			
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Naval Hospital				STREET ADDRESS (If rural give location) 709 G Street, S.E.			
3. NAME OF DECEASED: (First) (Middle) (Last) Valentine (n) HEGEDUS				4. DATE (Month) (Day) (Year) OF DEATH: June 1 19 55			
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: 8-20-87	9. AGE last birthday 67 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Barber		10B. KIND OF BUSINESS OR INDUSTRY: Barber		11. BIRTHPLACE (State or foreign country): Hungary		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME: Valentine HEGEDUS				14. MOTHER'S MAIDEN NAME: Sarah SERRIO			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. (If Yes, give war or dates of service) Unknown		17. INFORMANT & ADDRESS: Son Louis Valentine HEGEDUS Same as above			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Obstruction, superior vena cava						3 wks	
ANTECEDENT CAUSE (S) DUE TO (B) Aneurysm, ascending aorta						24 months	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Pneumonia, lobar.						3 days.	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED White <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 9 May , 1955, to 1 June , 1955 that I last saw the deceased alive on 1 June , 1955, and that death occurred at 2:26AM , from the causes and on the date stated above.							
SIGNATURE E. J. RUPNIK		ADDRESS		DATE SIGNED			
E. J. RUPNIK LT MC USN U. S. Naval Hospital, NNMC, Bethesda, Maryland							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		DATE THEREOF 2 June 1955		NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		LOCATION (City, town, or county) (State) Prince George Co, Maryland	
DATE REC'D BY LOCAL REGISTRAR 1 June 1955		REGISTRAR'S SIGNATURE Mary E. Carrelly		24. FUNERAL DIRECTOR Ryan Funeral Home		ADDRESS 317 Pennsylvania Avenue, Washington, D.C.	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUN 3 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05744

5755

CERTIFICATE OF DEATH

Reg. Dist. No. 216

Item 9, Film G183, 6/30/55 Key

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>47X-3</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Bethesda</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital</u>				STREET ADDRESS (If rural give location) <u>5101 - 38th St. N.W.</u>			
3. NAME OF DECEASED: (First) <u>William</u> (Middle) <u>Ray</u> (Last) <u>Henderson</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>June 22 1955</u>			
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH: <u>7/27/83</u>	9. AGE last birthday: <u>71</u> yrs.	IF UNDER 1 YEAR: Months Days		IF UNDER 24 HRS: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Schoolteacher</u>		11. BIRTHPLACE (State or foreign country): <u>Wilbur, Oregon</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Alvin Perry Henderson</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Henderson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS: <u>Lela H. Mead (Daughter) (Home address)</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
332X IMMEDIATE CAUSE		(A) <u>Cerebral thrombosis.</u>					
ANTECEDENT CAUSE (S)		DUE TO					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(B) <u>900.0</u>					
		(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Fractured left hip - fracture displaced</u>						48 h.	
19A. DATE OF OPERATION: <u>6/20/55</u>		19B. MAJOR FINDINGS OF OPERATION: <u>① Dislocated shoulder ② Hip swelling</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21B. PLACE (Home, farm, factory, of injury street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? <u>5101 38th St. N.W. Wash. D.C.</u>			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: <u>6/20/55 3:20 P.M.</u>		21E. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input checked="" type="checkbox"/> at work		21F. HOW DID INJURY OCCUR? <u>fell on stairs</u>			
22. I hereby certify that I attended the deceased from <u>6/20</u> , 19 <u>55</u> , to <u>6/22</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>6/21</u> , 19 <u>55</u> , and that death occurred at <u>12:50</u> P.M., from the causes and on the date stated above.							
SIGNATURE <u>Arthur B. Roberts</u>		ADDRESS <u>M.D. 104 Chevy Chase Dr.</u>		DATE SIGNED <u>6/24/55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Cremation</u>		DATE THEREOF: <u>6/24/55</u>		NAME OF CEMETERY OR CREMATORY: <u>Cedar Hill Crematory</u>		LOCATION (City, town, or county) (State): <u>Prince Geo. Co., Md.</u>	
DATE REC'D BY LOCAL REGISTRAR: <u>6/24/55</u>		REGISTRAR'S SIGNATURE: <u>Bessie M. Thompson</u>		24. FUNERAL DIRECTOR: <u>Martin W. Hyson Co.</u>		ADDRESS: <u>1300 - N St. N.W. Wash. D.C.</u>	

Reported & Approved
by the Monks
1550 22 June 55

BUREAU V. S.

JUN 27 1955

RECEIVED

5756 CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY	Montgomery	MARYLAND	STATE District of Columbia
CITY (If outside corporate limits, write RURAL OR and give nearest town)	Bethesda Rural	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington, D.C. 47X-3
HOSPITAL OR INSTITUTION OR STREET ADDRESS	U. S. Naval Hospital	STREET ADDRESS	719 Rittenhouse Street, N.W. ✓
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year) OF DEATH:	
Alfred (n) HEUMANN		June 15 19 55	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
Male	White	Married	8-2-05
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	9. AGE last birthday IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
Manager Women's Apparell Shop			49 yrs.
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
Germany		US	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
Isodor HEUMAN		Unknown Deceased	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give year or dates of service)		16. SOCIAL SECURITY NO.	
Yes WW II		Unknown	
17. INFORMANT & ADDRESS:			
Wife Mrs. Irma B. HEUMANN		Same as above	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
151X	(A) Carcinoma of Stomach	unknown
IMMEDIATE CAUSE	DUE TO	
ANTECEDENT CAUSE (S)		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE	(B) DUE TO	
STATING UNDERLYING CAUSE LAST.	(C)	

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	
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19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
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21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 15 Jun., 1955, to 15 Jun., 1955, that I last saw the deceased alive on 15 Jun., 1955, and that death occurred at 10:43 PM, from the causes and on the date stated above.

SIGNATURE	ADDRESS	DATE SIGNED
W. I. BREUD LT MC USN U. S. Naval Hospital, DNNMC, Bethesda, Maryland		

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	17 June 1955	Achduth Chevra Mt Lebanon Cemetery, Maryland	

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
16 June 1955	Harry L. Canally	Danzansky & Son Funeral Home	3501 14th Street, N.W. Washington, D.C.

BUREAU V. S.

JUN 17 1955

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 216

5757

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>D.C.</u>	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bethesda</u>	LENGTH OF STAY (in this place) <u>6 hours</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Washington</u> <u>47X-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban</u>		STREET ADDRESS (If rural give location) <u>3507 W Place. N.W.</u> ✓	
3. NAME OF DECEASED: (First) <u>Flora</u> (Middle) <u>Robinson</u> (Last) <u>Howell</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>June 26 1955</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH: <u>Aug. 20, 1870</u>
9. AGE last birthday: <u>84</u> yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY: <u>Housewife</u>	11. BIRTHPLACE (State or foreign country): <u>Illinois</u>
13. FATHER'S NAME: <u>Franklin Robinson</u>		14. MOTHER'S MAIDEN NAME: <u>Isabel Spence</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		17. INFORMANT & ADDRESS: <u>Mrs. Gladys Weidman</u> <u>3507 W Place N.W. Washington D.C.</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
(A) IMMEDIATE CAUSE <u>Atrophic Cirrhosis of Liver</u>		<u>10 yrs</u>
(B) ANTECEDENT CAUSE (S) <u>Get</u>		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Generalized Arteriosclerosis</u>		<u>20 yrs</u>

19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Jan</u> , 19 <u>50</u> , to <u>June 26</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>June 26</u> , 19 <u>55</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.					
SIGNATURE <u>George Sharpe</u>		ADDRESS <u>M.D. 10644 Conn. Ave</u>		DATE SIGNED <u>27 June 55</u>	
23. BURIAL, CREMATION, (REMOVAL) (SPECIFY)		DATE THEREOF <u>6-28-55</u>		NAME OF CEMETERY OR CREMATORY <u>LEBANON</u>	
				LOCATION (City, town, or county) (State) <u>LEBANON INDIANA</u>	
DATE REC'D BY LOCAL REGISTRAR <u>6/28/55</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		24. FUNERAL DIRECTOR <u>1756 P St. N.W.</u> <u>W.A. S.M. D.C.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUN 30 1955

RECEIVED

5693

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	(see birth cert.)	
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	STATE <u>Maryland</u>	COUNTY <u>Pr. Geo.</u>
17 TOWN <u>Jakoma Park.</u>	5 hrs 13 min	CITY (If outside corporate limits, write RURAL and give nearest town)	1615-2
HOSPITAL OR INSTITUTION OR STREET ADDRESS	STREET ADDRESS (If rural give location)		
75 <u>Wash. San. & Hosp.</u>	<u>2109 Guilford Road</u>		
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) (Middle) (Last)		OF DEATH: <u>June 9 1955</u>	
5. SEX: 7e		6. COLOR OR RACE: <u>White</u>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>		8. DATE OF BIRTH: <u>6-9-55</u>	
9. AGE last birthday		10. CITIZEN OF WHAT COUNTRY?	
yrs. Months Days Hours Min.		5 13	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	
		11. BIRTHPLACE (State or foreign country): <u>Maryland.</u>	
13. FATHER'S NAME: <u>John Paul Huber</u>		14. MOTHER'S MAIDEN NAME: <u>Barbara Mc Donough</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		17. INFORMANT & ADDRESS:	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
776X IMMEDIATE CAUSE (A) <u>Prematurity</u>		
ANTECEDENT CAUSE (S) DUE TO		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		
(B) DUE TO		
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6/9, 1955, to 6/9, 1955, that I last saw the deceased alive on 6/9, 1955, and that death occurred at 8:45 PM, from the causes and on the date stated above.

SIGNATURE <u>Dr. Diamond</u>	ADDRESS <u>8224 - 92 Ave</u>	DATE SIGNED <u>6/10/55</u>
M. D.		
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY
<u>Burial</u>	<u>6-10-55</u>	<u>St. Mary's Cemetery, City. Va.</u>
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR
<u>6-14-55</u>	<u>Frances Peter</u>	<u>320 S. ... St. City. Va.</u>

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUN 16 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5758

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05748

Reg. Dist.

No. 212

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Montg</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)		OR	
TOWN <u>Poolesville</u>		<u>D.O.A.</u>		TOWN <u>Poolesville</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Potomac R. at Edmund Ferry</u>				STREET ADDRESS (If rural, give location) <u>1</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Sorothy Ignatia Hunt</u>				<u>June 20 1955</u>			
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH:	
<u>Female</u>		<u>white</u>		<u>Single</u>		<u>6-11-41</u>	
9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.							
<u>14</u> yrs. Months Days Hours Min.							
10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>School</u>				10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>md</u>	
						12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Woodrow W. Hunt</u>				14. MOTHER'S MAIDEN NAME: <u>Mary E. Smith</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.: <u>None</u>		17. INFORMANT & ADDRESS: <u>Woodrow W. Hunt (father) Same as Decd</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
<u>929.9</u> Immediate cause (a) <u>Asphyxia</u> DUE TO						<u>Sudden</u>	
Antecedent cause(s) (b) <u>drowning</u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County)		21d. (State)	
				<u>15</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>6-20-55 4:4 P.M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>drowned while swimming</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/>, Accident <input checked="" type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.							
SIGNATURE <u>Frank J. Broschart</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>6-20-55</u>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input checked="" type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>6/23/55</u>		NAME OF CEMETERY OR CREMATORY <u>Monocacy</u>		LOCATION (City, town, or county) (State) <u>Beallsville, md</u>	
DATE REC'D BY LOCAL REG. <u>6/24/55</u>		REGISTRAR'S SIGNATURE <u>Charles W. Elgin</u>		24. FUNERAL DIRECTOR <u>William B. Hiltope</u>		ADDRESS <u>Barnesville, md</u>	

RECEIVED
JUN 23 1955
BUREAU V. S.

5759

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>California</u>		COUNTY	
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
56 TOWN <u>Silver Spring</u>				TOWN <u>Los Angeles</u> 43X-3			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
00 2826 Munson Street							
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)		OF DEATH: <u>June</u> <u>9</u> <u>1955</u>			
Clara Antonia Jehle							
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 24 HRS. Hours Min.
Female	White	Single	July 16, 1880	74 yrs.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
Artist		Self-employed		St. Paul, Minn.		U.S.A.	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
John Jehle				Rosa Denzer			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.):		16. SOCIAL SECURITY NO.		17. INFORMANT'S ADDRESS:			
no		none		Mr. Robert A. Jehle, 2826 Munson St. Glenmont, Silver Spring, Md.			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
331X IMMEDIATE CAUSE							3 months
(A) <u>Cerebral Hemorrhage.</u> DUE TO							
ANTECEDENT CAUSE (S):							
(B) <u>Arteriosclerosis, Generalized</u> DUE TO							10 years
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							15 years
<u>Carcinoma Left Breast</u>							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April</u> , 1950, to <u>9 June</u> , 1955, that I last saw the deceased alive on <u>1 June</u> , 1955, and that death occurred at <u>11:45</u> A.M. from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
<u>Dr. B. Green M.D.</u>		<u>7112 Willow Ave Takoma Park</u>		<u>9 June 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Cremation		6/9/55		Ft. Lincoln Crematory		Prince Geo. County, Md.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
6-9-55		<u>Francis Potter</u>		<u>Warner E. Humphrey</u>		8434 Ga. Ave. Silver Spring, Md.	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 8

JUN 13 1955

RECEIVED

5760

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>56</u> TOWN <u>Silver Spring.</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Silver Spring</u> <u>56.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>9310 Old Bladensburg Road</u>				STREET ADDRESS (If rural give location) <u>9310 Old Bladensburg Road</u> <u>1</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Johanna (Hanna) T. Johnson</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>June</u> <u>6</u> <u>19 55</u>			
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH: <u>April 4, 1881</u>	9. AGE last birthday <u>74</u> yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 24 HRS. Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Homemaker</u>			10B. KIND OF BUSINESS OR INDUSTRY: <u>Own home</u>		11. BIRTHPLACE (State or foreign country): <u>Nyvik, Sweden</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME: <u>Per Zetterlund</u>				14. MOTHER'S MAIDEN NAME: <u>Christina Persdotes</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Mrs. Edna C. Lundburg, 9310 Old Bladensburg Rd.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<u>442X</u>							
IMMEDIATE CAUSE (A) <u>Cerebral Edema</u>						<u>14 days.</u>	
ANTECEDENT CAUSE (S) DUE TO (B) <u>Cardio-vascular renal disease</u>						<u>2 yrs.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Arterio-sclerosis & Hypertension</u>						<u>5 yrs.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>8/29</u> , 19 <u>49</u> , to <u>6/6</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5/31</u> , 19 <u>55</u> , and that death occurred at <u>12:10 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Francis J. Richardson</u>				ADDRESS <u>M.D. 7717 Alaska Ave N.W. Wash D.C.</u> DATE SIGNED <u>6/4/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Trans. & Burial</u>		DATE THEREOF <u>6/8/55</u>		NAME OF CEMETERY OR CREMATORY <u>Oneota Cemetery</u>		LOCATION (City, town, or county) (State) <u>Duluth, Minn.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>6-9-55</u>		REGISTRAR'S SIGNATURE <u>Francis J. Richardson</u>		24. FUNERAL DIRECTOR <u>Warner & Pumphrey</u>		ADDRESS <u>8434 Georgia Ave. Silver Spring, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

This certificate signed with the
knowledge and permission of Dr.

Brochant.

6/6/55

J. L. Richard M.D.

JUN 18 1955

BUREAU V. 2

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 216

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>D.C.</u>	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Bethesda</u>		CITY (If outside corporate limits write RURAL and give nearest town) <u>Washington</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban</u>		STREET ADDRESS (If rural, give location) <u>1214 Penn St. N.E.</u>	
3. NAME OF DECEASED: (Type or Print) <u>Leslie (First) Henry Johnson</u>		4. DATE OF DEATH: (Month) <u>June</u> (Day) <u>18</u> (Year) <u>1955</u>	
5. SEX: <u>M.</u>	6. COLOR OR RACE: <u>C.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH: <u>Sept. 10, 1929</u>
9. AGE last birthday: <u>25</u> yrs.		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Truck Driver - Beauty Supplies</u>		11. BIRTHPLACE (State or foreign country): <u>Washington D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME: <u>Richard Johnson</u>	
14. MOTHER'S MAIDEN NAME: <u>Carrie L. Johnson</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	
16. SOCIAL SECURITY No.: <u> </u>		17. INFORMANT & ADDRESS: <u>1214 Penn St. N.E. Washington D.C.</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
Immediate cause (a) <u>Cardiac Decompensation Acute</u> DUE TO <u>with recent tension</u> Antecedent cause(s) (b) <u>Coronary Thrombosis, Left anterior descend.</u> Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u>Coronary Atherosclerosis</u>		<u>10 mos.</u> <u>3 wks.</u> <u>1 yr.</u>
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19a. DATE OF OPERATION: <u> </u>		19b. MAJOR FINDING OF OPERATION: <u> </u>
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21b. PLACE (Home, farm, factory, street, office bldg., etc., INJURY)	21c. (City or town) (County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR?
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		
SIGNATURE <u>Frank J. Brochert</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>6-18-55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>
23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY
<u>Burial</u>	<u>6-23-55</u>	<u>Woodlawn</u>
LOCATION (City, town, or county) (State)	<u>Washington D.C.</u>	
24. FUNERAL DIRECTOR	ADDRESS	
<u>Frazier's Funeral Home</u>	<u>389 Rt. AVE</u>	
<u>Washington, D.C.</u>	<u>Nat</u>	

DATE REC'D BY LOCAL REG.

6/20/55

REGISTRAR'S SIGNATURE

Bessie M. Thompson

24. FUNERAL DIRECTOR

Frazier's Funeral Home

ADDRESS

389 Rt. AVE

12

1914
1914

Sept 10, 1914

Richard Johnson
Truck Driver
1914

RECEIVED
JUN 22 1955
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK: Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5762

05752

Reg. Dist. 217

No. 785

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>DC</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR			
TOWN <u>Obney</u>		<u>2 1/2 days</u>		TOWN <u>Washington</u> <u>47X-3</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Monk Co. Gen Hosp.</u>				STREET ADDRESS (If rural, give location) <u>1015 N St. N.W.</u> ✓			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH			
(First) <u>Estelle</u>		(Middle) <u>Josephine</u>		(Last) <u>Jones</u>		(Month) (Day) (Year) <u>June 14 1955</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>col</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>Dec 21 1936</u>	9. AGE last birthday: <u>18</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months Days		Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>domestic home</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>home</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Cornelius Jones</u>				14. MOTHER'S MAIDEN NAME: <u>Margaret Stewart</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>—</u>		16. SOCIAL SECURITY No.: <u>no</u>		17. INFORMANT & ADDRESS: <u>Hosp records</u>			

18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
<u>823X</u>		(a) Immediate cause <u>Cerebral hemorrhage + laceration</u>				<u>2 1/2 days</u>	
		DUE TO					
Antecedent cause(s)		(b) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last <u>fracture of skull</u>					
		DUE TO					
		(c) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY) <u>highway</u>		21c. (City or town) (County) (State) <u>Highland Howard MD</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>6-12-55 4 A.M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Passenger in auto which left highway</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/>, Accident <input checked="" type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.							
SIGNATURE <u>Frank Broschart</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>6-14-55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>June 17 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Green Spring</u>		LOCATION (City, town, or county) (State) <u>Harford Co. Md.</u>	
DATE REC'D BY LOCAL REG. <u>June 16 - 55</u>		REGISTRAR'S SIGNATURE <u>G. L. Lewis M.D.</u>		24. FUNERAL DIRECTOR <u>R. Madison Mitchell</u>		ADDRESS <u>Harford Co., Md.</u>	
<u>Bertrude B. Lawler</u>							

RECEIVED

JUN 20 1955

BUREAU V. S.

5763

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>56 Silver Spring</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>14424 Colesville Road 56</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00 Home 942 GENEVA AVE</u>				STREET ADDRESS (If rural give location) <u>Silver Spring, Md.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>VERNA AMANDA JONES</u>				<u>June 6 19 55</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Female</u>	<u>white</u>	<u>married</u>	<u>March 2-1889</u>	<u>66</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>-</u>		<u>NY - Penn.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>ADAM CLARKE MCCLINTOCK</u>				<u>Joséphine Welsh</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service):				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<u>NO</u>				<u>-</u>		<u>Robert N. Jones - Colesville Rd. S.S. Md.</u>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
170X IMMEDIATE CAUSE (A) <u>Carcinoma of breast</u>						<u>about 1 yr</u>	
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Feb</u> , 19 <u>55</u> to <u>June 6</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>June 6, 1955</u> , and that death occurred at <u>11:30</u> M. from the causes and on the date stated above.							
SIGNATURE <u>William D. And</u>				ADDRESS <u>Silver Spring</u>		DATE SIGNED <u>6 June 55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>6-9-55</u>		<u>Fort Lincoln Cem.</u>		<u>Prince Georges Co. Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>6-9-55</u>		<u>Francis Potter</u>		<u>The S.H. Hines Co</u>		<u>2901-14th St. N.W. Wash. D.C.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUN 13 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5764

CERTIFICATE OF DEATH

Reg. Dist. No. 215

05754

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>District of Columbia</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
<u>X</u> TOWN <u>Bethesda</u> Rural		<u>40 days</u>		<u>Washington, D.C.</u>		<u>47X-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>57</u> <u>U. S. Naval Hospital</u>				<u>4015 Benton Street, N.W.</u> ✓			
3. NAME OF DECEASED:				4. DATE OF DEATH:			
(First)		(Middle)		(Last)		(Month) (Day) (Year)	
(Type or Print)		<u>William</u>		<u>Henry</u>		<u>JORDAN</u>	
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
<u>Male</u>		<u>White</u>		<u>Widowed</u>		<u>2-19-89</u>	
9. AGE last birthday		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
<u>66</u> yrs.		Months		Days		Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:			
<u>Communications operator</u>				<u>Retired</u>			
11. BIRTHPLACE (State or foreign country):				12. CITIZEN OF WHAT COUNTRY?			
<u>Washington, D.C.</u>				<u>U.S.</u>			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>William H. JORDAN</u>				<u>Fannie HAMMOND</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
<u>yes</u> ✓ <u>1917-1919</u>				<u>Same as above</u>			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE				(A) <u>Hypertensive and arterio-</u>			
ANTECEDENT CAUSE (S)				DUE TO <u>sclerotic heart disease</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				(B) <u>years</u>			
(C) <u>Diabetes mellitus</u>				<u>years</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY?				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)			
				21C. WHERE DID (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
				21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12 May</u> , 19 <u>55</u> , to <u>21 June</u> , 19 <u>55</u> that I last saw the deceased alive on <u>21 June</u> , 19 <u>55</u> , and that death occurred at <u>8:40P</u> M, from the causes and on the date stated above.							
SIGNATURE				ADDRESS			
<u>M. Eugene Flipse</u>				<u>Bethesda, Maryland</u>			
DATE SIGNED							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)				NAME OF CEMETERY OR CREMATORY			
<u>Burial</u>				<u>Arlington National</u>			
DATE THEREOF				LOCATION (City, town, or county) (State)			
<u>6-24-55</u>				<u>Arlington, Virginia</u>			
24. FUNERAL DIRECTOR				ADDRESS			
DATE REC'D BY LOCAL REGISTRAR							
<u>22 June 1955</u>				<u>S. H. Hines Funeral Home</u>			
REGISTRAR'S SIGNATURE							
<u>Mary L. Casselley</u>				<u>2901 14th Street, N.W., Washington, D.C.</u>			

BUREAU V. S.

JUN 24 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 05755
5765 CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Ohio</u>		COUNTY <u>-</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		LENGTH OF STAY (in this place) <u>25 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Dundas</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>The Clinical Center</u> <u>Nat'l Institutes of Health</u>				STREET ADDRESS (If rural give location) <u>Route 2</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Virgil</u> <u>None</u> <u>Kendricks</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>June</u> <u>10</u> <u>1955</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>April 25, 1915</u>	9. AGE last birthday <u>40</u> yrs.	IF UNDER 1 YEAR Months <u>1</u> Days <u>15</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Farming - self</u>		11. BIRTHPLACE (State or foreign country): <u>Kentucky</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Nevada Kendricks</u>				14. MOTHER'S MAIDEN NAME: <u>Sophie Thacker</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>yes</u> <input checked="" type="checkbox"/> (If Yes, give war or dates of service) <u>WW II</u>		16. SOCIAL SECURITY NO. <u>233-12-8893</u>		17. INFORMANT & ADDRESS: <u>The medical record, The Clinical Center</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				<u>Congestive heart failure due</u>			
IMMEDIATE CAUSE <u>411X</u>				<u>Years</u>			
ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				(A) <u>to Aortic Stenosis</u> DUE TO (B) <u></u> DUE TO (C) <u></u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>June 8, 1955</u>		19B. MAJOR FINDINGS OF OPERATION <u>Aortic Stenosis</u>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>none</u>		21C. WHERE DID (City or town) INJURY OCCUR? <u>none</u>		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M. <u></u>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 16</u> , 1955, to <u>June 10</u> , 1955, that I last saw the deceased alive on <u>June 10</u> , 1955, and that death occurred at <u>10:25 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>John Harold Key, M.D.</u>				ADDRESS <u>The Clinical Center</u> <u>M. D. National Institutes of Health</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial-transit</u>		DATE THEREOF <u>6/11/1955</u>		NAME OF CEMETERY OR CREMATORY <u>McArthur Cemetery</u>		LOCATION (City, town, or county) (State) <u>Vinton County Ohio</u>	
DATE REC'D BY LOCAL REGISTRAR <u>6/13/55</u>		REGISTRAR'S SIGNATURE <u>Bennie M. Thompson</u>		24. FUNERAL DIRECTOR <u>Robert A. Humphrey</u>		ADDRESS <u>Bethesda, Md.</u>	

BUREAU V. S.

JUN 15 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05756

5768

CERTIFICATE OF DEATH

Reg. Dist. No.

216

Item 9, Film G182 6-13-55 et

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Bethesda</u>		LENGTH OF STAY (in this place) <u>4 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Kensington</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>74 Suburban Hospital</u>				STREET ADDRESS (If rural give location) <u>4405 Glenridge Rd.</u>			
3. NAME OF DECEASED: (First) <u>William</u> (Middle) <u>Louis</u> (Last) <u>Kirkland</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>July 5 1955</u>			
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>married</u>	8. DATE OF BIRTH: <u>Nov. 16, 1893</u>	9. AGE last birthday <u>61</u> <u>11/7</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>clerk</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>William (D)</u>				14. MOTHER'S MAIDEN NAME: <u>Kreamer (D)</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> (If Yes, give war or dates of service) <u>1914</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Doris (wife), 4405 Glenridge Rd., Kensington</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>420.1 Congestive Heart Failure</u>		DUE TO				<u>Less than 2 hrs.</u>	
ANTECEDENT CAUSE (S) <u>Coronary Thrombosis</u>		DUE TO				<u>3 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan</u> , 19 <u>55</u> , to <u>present</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>June 5</u> , 19 <u>55</u> , and that death occurred at <u>4:15 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>John C. K. Yu</u>		ADDRESS <u>M. D. 11718 Viers Mill Rd., S.S., Md.</u>		DATE SIGNED <u>6-5-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>		DATE THEREOF <u>5-5-55</u>		NAME OF CEMETERY OR CREMATORY <u>Wash.</u>		LOCATION (City, town, or county) (State) <u>Wash. D.C.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>6/6/55</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		24. FUNERAL DIRECTOR <u>Francis J. Gollin</u>		ADDRESS <u>3821-14th N.W.</u>	

BUREAU V. S.

JUN 8 1955

RECEIVED

5767

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u> MARYLAND	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>
X TOWN	LENGTH OF STAY (in this place) <u>6-1-55/6-9-55</u>	OR TOWN	X
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban</u>	STREET ADDRESS (If rural give location) <u>4519 Highland Ave.</u>		
3. NAME OF DECEASED: (Type or Print)		4. DATE OF DEATH:	
(First) <u>Sue</u> (Middle) <u>M.</u> (Last) <u>Kline</u>		(Month) <u>June</u> (Day) <u>9</u> (Year) <u>1955</u>	
5. SEX: <u>F.</u>	6. COLOR OR RACE: <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>11-22-12</u>	8. DATE OF BIRTH: <u>42</u> yrs. <u>7</u> Months <u>17</u> Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stenographer</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>N.I.H.</u>	11. BIRTHPLACE (State or foreign country): <u>Alabama</u>
13. FATHER'S NAME: <u>Joseph McCluskey</u>		14. MOTHER'S MAIDEN NAME: <u>Sue Johnson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)		17. INFORMANT & ADDRESS: <u>J.P. McCluskey, Jr. Bro. Empora, Miss.</u>	
16. SOCIAL SECURITY NO. <u>Yes No. unknown</u>		12. CITIZEN OF WHAT COUNTRY: <u>U.S.</u>	
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
330X IMMEDIATE CAUSE (A) <u>Cerebral hemorrhage</u>		<u>72 minutes</u>	
ANTECEDENT CAUSE (S) (B) <u>Ruptured berry aneurysm</u>		<u>40? years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Circle of Willis congenital</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Hypertension</u>		<u>4 1/2 years</u>	
19A. DATE OF OPERATION: <u>(none)</u>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>May 26, 1955</u> , to <u>June 9, 1955</u> , that I last saw the deceased alive on <u>June 8, 1955</u> , and that death occurred at <u>6:40 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>James W. Long</u>		DATE SIGNED <u>June 9, 1955</u>	
M.D. <u>915-19th St. N.W. Wash. D.C.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial-Transit</u>		NAME OF CEMETERY OR CREMATORY <u>Highland Memorial Park</u>	
DATE REC'D BY LOCAL REGISTRAR <u>6/11/55</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	
24. FUNERAL DIRECTOR <u>Robert A. Humphrey</u>		ADDRESS <u>Bethesda, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUN 13 1955

RECEIVED

5694

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Montgomery	MARYLAND	STATE md.	COUNTY Prince George
CITY (If outside corporate limits write RURAL) Takoma Park	LENGTH OF STAY (in this place) 2 days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Adelphi	16X-2
HOSPITAL OR INSTITUTION OR STREET ADDRESS Washington Sanitarium & Hospital		STREET ADDRESS 9233 Riggs Rd.	(If rural give location) ✓
3. NAME OF DECEASED: (First) Mary (Middle) — (Last) Krever		DATE (Month) (Day) (Year) OF DEATH: 6-23-1955	
5. SEX: Fe	6. COLOR OR RACE: white	8. DATE OF BIRTH: 8-15-80	9. AGE last birthday 74 yrs.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Hsuf.		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): Russia
13. FATHER'S NAME: Jacob Cogen		14. MOTHER'S MAIDEN NAME: Hanna ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): no (If Yes, give war or dates of service)		17. INFORMANT & ADDRESS: Hospital Record	
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) Cardiac decompensation		30 months	
ANTECEDENT CAUSE (S)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(B) Hypertensive and coronary arteriosclerotic	
		(C) heart disease	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		10 years.	
19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Sept , 1952, to June 23 , 1955, that I last saw the deceased alive on June 23 , 1955, and that death occurred at 6:00pm , from the causes and on the date stated above.			
SIGNATURE Adam H. Traumm		DATE SIGNED June 23 1955	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		NAME OF CEMETERY OR CREMATORY Georgetown Mem. Park	
DATE REC'D BY LOCAL REGISTRAR JUNE 24 1955		24. FUNERAL DIRECTOR Goldberg Funeral Home Wash. DC	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUN 27 1955

RECEIVED

5711

CERTIFICATE OF DEATH

Reg. Dist. No. 213

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		LENGTH OF STAY (in this place) <u>6 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Route 2 Seven Locks Road</u>				STREET ADDRESS (If rural give location) <u>Seven Locks Road Route #2.</u>		<u>1</u>	
3. NAME OF DECEASED: (Type or Print) <u>CORINNE</u> (Middle) <u>SASSER</u> (Last) <u>KUNKEL</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>JUNE 13 1955</u>			
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>MARCH 18 1904</u>	9. AGE last birthday <u>51</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife Secretary</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>HOUSTON TEXAS</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>R. F. SASSER</u>				14. MOTHER'S MAIDEN NAME: <u>LORENA MAUD CHISOLM</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS: <u>Mr Charles Kunkel Seven Locks Rd. Rt 2#</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Intestinal Obstruction</u>						<u>4 wks</u>	
ANTECEDENT CAUSE (S) (B) <u>CARCINOMA Bowel</u>						<u>5 Months</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>Feb 1955</u>		19B. MAJOR FINDINGS OF OPERATION <u>CARCINOMA Bowel Primary Site</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from, 19....., to <u>JUNE 13</u> , 1955, that I last saw the deceased alive on <u>JUNE 13</u> , 1955, and that death occurred at <u>5:35 P.</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Charles Jerome Evending</u>		M.D. <u>4921 Steeles Ave</u>		ADDRESS <u>Bethesda, Md.</u>		DATE SIGNED <u>6/13/1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>6-15-55</u>		NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>		LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>6/15/55</u>		REGISTRAR'S SIGNATURE <u>Laurel H. Bryant</u>		24. FUNERAL DIRECTOR <u>Robert R. Humphrey</u>		ADDRESS <u>Bethesda, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUN 16 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

5712

CERTIFICATE OF DEATH

05760

213

Reg. Dist. No. 276

1. PLACE OF DEATH: COUNTY <u>Montgomery</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rockville Pike</u>		MARYLAND LENGTH OF STAY (In this place) <u>35 yrs.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Montgomery</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> TOWN STREET ADDRESS (If rural, give location) <u>Rockville Pike</u>	
3. NAME OF DECEASED (Type or Print) <u>Ella</u> (First) <u>A.</u> (Middle) <u>LAKE</u> (Last)		4. DATE OF DEATH <u>June</u> (Month) <u>6</u> (Day) <u>1953</u> (Year)			
5. SEX <u>F</u>	6. COLOR OR RACE <u>Wh</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>Sept. 7, 1869</u>	9. AGE last birthday <u>85</u> yrs.	If under 1 year Months <u>8</u> Days <u>29</u> If under 24 hrs. Hours <u>00</u> Min. <u>00</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>	
13. FATHER'S NAME <u>Charles Lake</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Betzel</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>None</u>		17. INFORMANT <u>Chas. E. Lake - nephew</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

153x
Immediate cause

(a) Carcinoma of Colon (Hepatic flexure) c

INTERVAL BETWEEN ONSET AND DEATH

2-3 yrs.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) metastases

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒
(STATE)

21. ACCIDENT (Specify) <u>SUICIDE</u> HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN)	(COUNTY)
TIME (Month) (Day) (Year) (Hour) <u>6/7/55</u> OF INJURY	INJURY OCCURRED While at <input type="checkbox"/> Not While <input type="checkbox"/> Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from June 4, 1953, to June 6, 1955, that I last saw the deceased

alive on June 4, 1953, and that death occurred at 5:17 A.M. from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>6-8-1955</u>	NAME OF CEMETERY OR CREMATORY <u>Rockville Union</u>	LOCATION (City, town, or county) <u>Montgomery Maryland</u>
DATE REC'D BY LOCAL REG. <u>6/7/55</u>	REGISTRAR'S SIGNATURE <u>Lawell H. Hingloap</u>	24. FUNERAL DIRECTOR <u>Robert A. Humphrey</u>	ADDRESS <u>Bethesda, Md.</u>

RECEIVED

BUREAU V. S.

JUN 10 1955

RECEIVED

5713

05761

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. 213No. 246

1. PLACE OF DEATH:

COUNTY Montgomery MARYLANDCITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Rockville LENGTH OF STAY (in this place) 3 yrsHOSPITAL OR INSTITUTION OR STREET ADDRESS R-1 Glen Rd

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MD COUNTY MontgCITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Rockville (rural) XSTREET ADDRESS (If rural, give location) R-1 Glen Rd 1

3. NAME OF DECEASED: (Type or Print)

(First)

(Middle)

(Last)

Joanne Taylor Lloyd

4. DATE OF DEATH (Month) (Day) (Year)

June 12 1955

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH:

2-25-1919

9. AGE last birthday:

36 yrs.

IF UNDER 1 YEAR

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

Ill.

11. BIRTHPLACE (State or foreign country):

Ill.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME:

Walter W. Taylor

14. MOTHER'S MAIDEN NAME:

Margaret Wells

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

Carl Lloyd (husband) Same as Item 2

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

420.1

Immediate cause

(a) DUE TO

Coronary occlusion

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH

Found dead in bed

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

Bronchial Asthmalife

19a. DATE OF OPERATION:

19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☒21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY

21c. (City or town) (County)

(State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

Frank J. ProschartCHIEF MEDICAL EXAMINER ☐

DATE SIGNED

DEPUTY MEDICAL EXAMINER ☐M. D. ASSISTANT MEDICAL EXAM. ☐6-12-55

23. BURIAL, CREMATION, REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

6-14-55Arlow HillSuitland Md.

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

6/14/55 6/2/55 Samuel H. TaylorJoe Jaworski 1756 Pa Ave N.W. Wash D.C.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 20 1955

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 05762

5768

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND <u>MD</u>	STATE <u>New York</u>	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	
X TOWN <u>Remington</u>	<u>2 Years</u>	<u>69X-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS	STREET ADDRESS (If rural give location)		
<u>Remington Gardens Nursing Home</u>	<u>3000 McComas Ave</u>		
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <u>John</u>	(Middle) <u>R</u>	(Last) <u>Blayd</u>	OF DEATH: <u>June 4</u> 19 <u>55</u>
5. SEX: <u>male</u>		6. COLOR OR RACE: <u>white</u>	
7. SINGLE. MARRIED. WIDOWED, DIVORCED. (Specify): <u>widowed</u>		8. DATE OF BIRTH: <u>July 2-1866</u>	
9. AGE last birthday: <u>88</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY: <u>retired</u>	
11. BIRTHPLACE (State or foreign country): <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Thomas Blayd</u>		14. MOTHER'S MAIDEN NAME: <u>Sarah Blissett</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.):		16. SOCIAL SECURITY NO.	
(If Yes, give war or dates of service)		17. INFORMANT & ADDRESS:	
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (A) <u>Senility</u>			<u>yr</u> <u>yr</u> <u>1 week</u>
ANTECEDENT CAUSE (B) <u>Gastrointestinal genl</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (C) <u>Neurotic (Terminal)</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>5/1/55</u> , 19 <u>55</u> , to <u>6/4/55</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>6/2/55</u> , 19 <u>55</u> , and that death occurred at <u>8:45</u> M, from the causes and on the date stated above.			
SIGNATURE <u>James A. Blayd</u>		M. D. <u>1 Kensington Md</u> ADDRESS <u>6/4/55</u> DATE SIGNED	
23. BURIAL, CREMATION REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	
<u>6-4-55</u>	<u>Cedar Hill</u>	<u>Switzerland Md</u>	
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	
<u>6-6-55</u>	<u>Frances Potter</u>	<u>Local Funeral Home</u> ADDRESS <u>4812 24 Ave</u>	

RECEIVED
JUN 8 1955

U.S. DEPT. OF JUSTICE



BUREAU V. S.

JUN 8 1955

RECEIVED

5769

CERTIFICATE OF DEATH

Reg. Dist. No. 211

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural- Damascus</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural- Damascus</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>R.F.D. # 3 Mt. Airy</u>		STREET ADDRESS (If rural give location) <u>R.F.D. # 3 Mt. Airy</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <u>Baby Boy</u>	(Middle) <u>Lyles</u>	(Month) <u>Jan</u>	(Day) <u>21</u> (Year) <u>1955</u>
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>Black</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>6-21-55</u>
9. AGE last birthday		IF UNDER 1 YEAR	
		Months	Days
		Hours	Min.
		<u>10</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Nr. Damascus, Md.</u>		<u>USA</u>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>John Lyles</u>		<u>Helena Genus</u>	
15. WAS DECEASED EVER IN U.S. ARMY FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
<u>No</u>		<u>--</u>	
17. INFORMANT & ADDRESS:			
<u>Mr. John Lyles, Mt. Airy, Md.</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Arteriosclerosis, bilateral</u>			<u>10 minutes</u>
ANTECEDENT CAUSE (S)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(B)			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY?			
YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21E. TIME (Month) (Day) (Year) (Hour) OF INJURY		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>6/21</u> , 19 <u>55</u> , to <u>6/21</u> , 19 <u>55</u> that I last saw the deceased alive on <u>6/21</u> , 19 <u>55</u> , and that death occurred at <u>1:30 A.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>James P. Kern</u>		DATE SIGNED <u>6/21/55</u>	
ADDRESS <u>Damascus, Md.</u>			
M. D. <u>Damascus, Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		24. FUNERAL DIRECTOR	
<u>Burial</u>		<u>Nr. Damascus, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>June 21, 1955</u>		REGISTRAR'S SIGNATURE <u>Della W. Burdette</u>	
		ADDRESS <u>Clin L. Molesworth, Damascus, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 2

JUN 23 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 05764
5770 CERTIFICATE OF DEATH

Reg. Dist. No. 211

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Damascus</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Damascus</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>R.F.D. # 3 Mt. Airy</u>				STREET ADDRESS (If rural give location) <u>R:F.D. # 3 Mt. Airy</u>		<u>1</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Baby Girl Lyles</u>				4. DATE OF DEATH: (Month) (Day) (Year) <u>June 51 1955</u>			
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>Black</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>June 21, 1955</u>	9. AGE last birthday: <u>yr.</u>	IF UNDER 1 YEAR: Months Days	IF UNDER 24 HRS: Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>--</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>--</u>		11. BIRTHPLACE (State or foreign country): <u>Nr. Damascus, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>John Lyles</u>				14. MOTHER'S MAIDEN NAME: <u>Helena Genus</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>--</u>		17. INFORMANT & ADDRESS: <u>Mr. John Lyles, Mt. Airy, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Catelectasis, bilateral</u>						<u>10 minutes</u>	
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6/21</u> , 19 <u>55</u> , to <u>6/21</u> , 19 <u>55</u> that I last saw the deceased alive on <u>6/21</u> , 19 <u>55</u> , and that death occurred at <u>1:35H</u> M, from the causes and on the date stated above.							
SIGNATURE <u>James P. Ken</u>				ADDRESS <u>Damascus, Md.</u>		DATE SIGNED <u>6/21/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>June 21, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Friendship</u>		LOCATION (City, town, or county) <u>Nr. Damascus, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>June 21, 1955</u>		REGISTRAR'S SIGNATURE <u>Lella V. Burdette</u>		24. FUNERAL DIRECTOR ADDRESS <u>Olin L. Molesworth, Damascus, Md.</u>			

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

116531X31V

BUREAU V. A.

JUN 28 1955

RECEIVED

05765

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5695

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Montgomery</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Montgomery</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
17 TOWN <i>Takoma Park</i>		24 days		TOWN <i>Gaithersburg</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS		(If rural, give location)			
75 <i>Washington Sanitarium Hospital</i>		<i>Marjorie Elizabeth</i>		2 Cedar Avenue			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<i>Marjorie Elizabeth MacKall</i>				<i>June 4 1955</i>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<i>Female</i>	<i>White</i>	<i>Widowed</i>	<i>7-27-92</i>	<i>62</i> yrs.	<i>11</i> Months	<i>54</i> Days	<i>Hours</i> <i>Min.</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<i>Housewife</i>				<i>Gaithersburg, Md.</i>		<i>U.S.A.</i>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<i>William M. Carlisle</i>				<i>Miriam Walker</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		18. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
<i>No</i>				<i>9107 Flower Ave. Mary C. Clarke R.H. S.S. Md.</i>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
171X IMMEDIATE CAUSE (A) <i>Metastatic Carcinoma of Cervix</i>							<i>2 yrs</i>
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<i>Sept. 1954</i>		<i>Carcinoma of cervix</i>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, etc.) OF INJURY		21C. WHERE DID INJURY OCCUR?		(City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>5-12, 1955</i> , to <i>6-4, 1955</i> , that I last saw the deceased alive on <i>6-8, 1955</i> , and that death occurred at <i>10:00 A</i> M, from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
<i>Paul V. Starr</i>		<i>M.D. Takoma Park, Md.</i>		<i>6-4-55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>6-6-55</i>		<i>Forest Oak Cemetery</i>		<i>Gaithersburg, Md.</i>	
DATE REC'D BY LOCAL REGISTRAR		REGISTER'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<i>June 7-1955</i>		<i>J. William Dadd</i>		<i>E. C. Sartorius</i>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUN 8 1955

RECEIVED

5771

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>D. C.</u>	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>X</u> TOWN <u>Bethesda</u>	LENGTH OF STAY (in this place) <u>120</u> days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Washington, D. C.</u> <u>47X-3</u>	
HOSPITAL OR INSTITUTE OR STREET ADDRESS <u>50 The Clinical Center National Institutes of Health</u>	STREET ADDRESS (If rural give location) <u>3685th 38th St. N. W.</u> ✓		
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Alice Marie Mahony</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>June 4 19 55</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>July 15, 1901</u>
9. AGE last birthday: <u>53</u> yrs.		IF UNDER 1 YEAR: Months Days	IF UNDER 24 HRS.: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Medical Secretary</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Medical</u>	
11. BIRTHPLACE (State or foreign country): <u>Mass.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>John Mahony</u>		14. MOTHER'S MAIDEN NAME: <u>Margaret Williams</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT & ADDRESS: <u>The medical record, The Clinical Center</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE <u>170X</u> (A) <u>Adenocarcinoma of the breast</u> DUE TO			
ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) _____ DUE TO			
(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>none</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>none</u>	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4 Jan</u> , 19 <u>55</u> , to <u>4 Jun</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>4 Jun</u> , 19 <u>55</u> , and that death occurred at <u>10:55 M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Harold Altman, M.D.</u>		DATE SIGNED <u>June 4, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal & Burial</u>		DATE THEREOF <u>6/4/55</u>	
NAME OF CEMETERY OR CREMATORY <u>ST JOSEPH</u>		LOCATION (City, town, or county) (State) <u>BOSTON MASS</u>	
DATE REC'D BY LOCAL REGISTRAR <u>6/6/55</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	
24. FUNERAL DIRECTOR <u>The S. H. Hines Co.</u>		ADDRESS <u>2901-14th St. N.W. Wash. D.C.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUN 8 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5772

CERTIFICATE OF DEATH

Reg. Dist. No. 216

05767

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u> MARYLAND		STATE <u>W. Virginia</u> COUNTY -	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Bethesda</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Salem,</u> <u>85X-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>The Clinical Center</u> <u>National Institutes of Health</u>		STREET ADDRESS (If rural give location) <u>Rural Delivery 2</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Donland Eugene Matthey</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>June 17</u> 19 <u>55</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>May 19, 1947</u>
9. AGE last birthday: <u>8</u> yrs.		IF UNDER 1 YEAR: Months <u>-</u> Days <u>28</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Child</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>--</u>	11. BIRTHPLACE (State or foreign country): <u>West Virginia</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME: <u>Fred Matthey</u>	
14. MOTHER'S MAIDEN NAME: <u>Blanch Robertson</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)	
16. SOCIAL SECURITY No. <u>None</u>		17. INFORMANT & ADDRESS: <u>The medical record, The Clinical Center</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Cerebral hemorrhage</u>			
ANTECEDENT CAUSE (B) <u>Acute lymphoblastic leukemia</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>none</u>		19B. MAJOR FINDINGS OF OPERATION: <u>none</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.) <u>none</u>	
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 2</u> , 19 <u>55</u> to <u>June 17</u> , 19 <u>55</u> that I last saw the deceased alive on <u>June 17</u> , 19 <u>55</u> , and that death occurred at <u>7:35 P.</u> M., from the causes and on the date stated above.			
SIGNATURE: <u>J. Zennaro</u>		ADDRESS: <u>The Clinical Center</u> <u>National Institutes of Health</u> <u>17 June 1955</u>	
DATE SIGNED: <u>6/18/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY): <u>Burial</u>		DATE THEREOF: <u>6-20-55</u>	
NAME OF CEMETERY OR CREMATORY: <u>K of P Memorial Pk</u>		LOCATION (City, town, or county) (State): <u>Harrison Co. W. Virginia</u>	
DATE REC'D BY LOCAL REGISTRAR: <u>6/18/55</u>		REGISTRAR'S SIGNATURE: <u>Bessie M. Thompson</u>	
FUNERAL DIRECTOR: <u>Robert A. Humphrey</u>		ADDRESS: <u>Bethesda, Md.</u>	

BUREAU V. S.

JUN 21 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2, Film 183 7-7-55 et

5696

CERTIFICATE OF DEATH

Reg. Dist. No. 223...

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u> MARYLAND		CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>TAKOMA PARK, MD</u>		STATE <u>MD.</u> COUNTY <u>Montgomery</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Takoma Park Wash. D. C. 47x3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>WASHINGTON SANITARIUM + HOSP</u>		LENGTH OF STAY (in this place) <u>4 mo 14 da</u>		STREET ADDRESS (If rural give location) <u>811 Butternut St. N. W.</u>		7444 Piney Branch Wash. 12 ✓	
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>LUCY GARNETT MAYO</u>				DEATH: <u>JUNE 8 19 55</u>			
5. SEX: <u>FE</u>	6. COLOR OR RACE: <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>SINGLE</u>	8. DATE OF BIRTH: <u>3/27/66</u>	9. AGE last birthday <u>89</u> yrs.	IF UNDER 1 YEAR Months <u>2</u> Days <u>11</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>NONE</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>AMERICAN</u>	
13. FATHER'S NAME: <u>ROBERT. MAYO</u>				14. MOTHER'S MAIDEN NAME: <u>ANNE. E. BASS</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>no</u>		16. SOCIAL SECURITY No. (If Yes, give war or dates of service)		17. INFORMANT & ADDRESS: <u>HOSPITAL RECORD</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <u>450.0</u>							
(A) DUE TO <u>CONGESTIVE HEART FAILURE</u>						<u>2 mos.</u>	
ANTECEDENT CAUSE (S):							
(B) DUE TO <u>GEN. ARTERIOSCLEROSIS</u>						<u>20 yrs</u>	
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>BRONCHO PNEUMONIA</u>							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>JAN 28</u> , 19 <u>55</u> , to <u>6-8</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>6-5-55</u> , 19 <u>55</u> , and that death occurred at <u>2:45 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Arthur E. Logue</u>		ADDRESS <u>M. D. 7600 Carroll Ave. Takoma Park Md</u>		DATE SIGNED <u>6-8-55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>cremation</u>		DATE THEREOF <u>6-11-55</u>		NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Country Burial, Md.</u>		LOCATION (City, town or county) (State)	
DATE REC'D BY LOCAL REGISTRAR <u>JUN 9-1955</u>		REGISTRAR'S SIGNATURE <u>J. Wilson Dook</u>		24. FUNERAL DIRECTOR <u>Robert R. Humphrey</u>		ADDRESS <u>Beth. Md.</u>	

RECEIVED

JUN 10 1955

BUREAU V. S.

5773

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Montgomery	MARYLAND	STATE Maryland	COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda	LENGTH OF STAY (in this place) 69 days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Resmor Sanitarium	STREET ADDRESS (If rural give location) 9511 Bulls Run Parkway		
3. NAME OF DECEASED: (First) (Middle) (Last) Olive Frances Lake McCOMAS		4. DATE (Month) (Day) (Year) OF DEATH: June 9 19 55	
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH: April 23, 1877
9. AGE last birthday 78 yrs.		IF UNDER 1 YEAR: Months 1 Days 16 IF UNDER 24 HRS. Hours Min. 	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife	10B. KIND OF BUSINESS OR INDUSTRY: - - - -	11. BIRTHPLACE (State or foreign country): District of Columbia	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Wilmot Lake		14. MOTHER'S MAIDEN NAME: Frances Clark	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No	16. SOCIAL SECURITY NO. (If Yes, give war or dates of service) None	17. INFORMANT & ADDRESS: 9511 Bulls Run Pkwy Elizabeth M. Sprague Bethesda, Md.	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE 420.0			
ANTECEDENT CAUSE (S) (A) Arteriosclerotic Heart disease - failure			8 yrs.
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) - - - -			
(C) - - - -			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Bronchiectasis			15 yrs.
19A. DATE OF OPERATION: none	19B. MAJOR FINDINGS OF OPERATION -		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY - - - - M.	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR? -	
22. I hereby certify that I attended the deceased from July 12, 1950 , to June 9, 1955 that I last saw the deceased alive on July 2, 1955 , and that death occurred at 4 P. M, from the causes and on the date stated above.			
SIGNATURE J. H. Jenson		DATE SIGNED July 9 '55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 6/11/55	NAME OF CEMETERY OR CREMATORY Rock Creek
DATE REC'D BY LOCAL REGISTRAR 6/11/55		REGISTRAR'S SIGNATURE Bessie M. Thompson	24. FUNERAL DIRECTOR Robert H. Humphrey
		ADDRESS Bethesda, Md.	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUN 13 1955

RECEIVED

Rock Creek

04/1/55

10/1/55

5774

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>MONTGOMERY</u>	MARYLAND	STATE <u>MARYLAND</u> COUNTY <u>MONTGOMERY</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	
56 TOWN <u>SILVER SPRING</u>	3 YRS	<u>SILVER SPRING</u> 56	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
00		8712 COLESVILLE ROAD	1
3. NAME OF DECEASED: (Type or Print)		4. DATE OF DEATH:	
(First) (Middle) (Last)		(Month) (Day) (Year)	
<u>PHILOMENA</u> <u>McCRORY</u>		6 - 25 1955	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, (Specify):	8. DATE OF BIRTH:
<u>FEMALE</u>	<u>WHITE</u>	<u>DIVORCED</u>	7-14-90
9. AGE last birthday		IF UNDER 1 YEAR Months Days Hours Min.	
64 yrs.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	
<u>HOUSEWIFE</u>			
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>NEW JERSEY</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>FRANCIS WILLIAMS</u>		<u>ELLEN FLYNN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
<u>No</u>		<u>161-07-9376</u>	
17. INFORMANT & ADDRESS:			
<u>Eleanor M. Forman</u>		<u>5901 Carlton Lane Wash. 16. D.C.</u>	
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
163X IMMEDIATE CAUSE		<u>Carcinoma of lung</u>	
ANTECEDENT CAUSE (S)		DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		DUE TO	
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>1953</u> , to <u>25 June, 1955</u> , that I last saw the deceased alive on <u>25 June, 1955</u> , and that death occurred at <u>1:15 P.M.</u> from the causes and on the date stated above.			
SIGNATURE		DATE SIGNED	
<u>William D. And</u>		<u>6/25/55</u>	
M. D. <u>Silver Spring</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	
<u>REMOVAL</u>		<u>6-25-55</u>	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>St. John's Cem.</u>		<u>Forest Glen, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		24. FUNERAL DIRECTOR ADDRESS	
<u>6-28-55</u>		<u>Francis Collins 3821-14th Ave Wash. D.C.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 3

JUN 30 1955

RECEIVED

5697

CERTIFICATE OF DEATH

Reg. Dist. No. 223...

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND <u>md</u>	STATE <u>md</u>	COUNTY <u>Montgomery</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Lakoma Park, Md.</u>	LENGTH OF STAY (in this place) <u>17</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Lakoma Park, Md.</u>	<u>17</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>75 Wash. Sun & Hosp</u>		STREET ADDRESS (If rural give location) <u>7104 Lycamore Ave</u>	<u>1</u>
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <u>Mc Elhenny</u>	(Middle) <u>Mc Elhenny</u>	(Last) <u>Mc Elhenny</u>	(Month) <u>6</u> (Day) <u>4</u> (Year) <u>1955</u>
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>single</u>	8. DATE OF BIRTH: <u>6-4-55</u>
9. AGE last birthday: <u>1</u> yrs. <u>1</u> month <u>30</u> days		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):	
10a. <u>usual</u>		10b. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>Takoma Park, Md.</u>		12. CITIZEN OF WHAT COUNTRY: <u>U.S.</u>	
13. FATHER'S NAME: <u>Loan E. Richeson</u>		14. MOTHER'S MAIDEN NAME: <u>Alma Rose Mc Elhenny</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	
(If Yes, give war or dates of service)		17. INFORMANT & ADDRESS:	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) <u>Prematurity - 5 1/2 months gestation</u>	ANTecedent CAUSE (B) <u>776x</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
-------------------------	----------------------------------	--

21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-4, 1955, to 6-4, 1955, that I last saw the deceased alive on 6-4, 1955, and that death occurred at 2:55 AM, from the causes and on the date stated above.

SIGNATURE B. Hughes M.D. ADDRESS Takoma Park, Md. DATE SIGNED 6-9-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>cremation</u>	<u>6-10-55</u>	<u>Wash. Sun & Hosp.</u>	<u>Takoma Park</u>	<u>md</u>
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>June 10-1955</u>	<u>J. Nelson Dodd</u>	<u>R. A. Hore, Md.</u>	<u>Takoma Park, Md.</u>	

2065161240

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUN 13 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05772

5775

CERTIFICATE OF DEATH

Reg. Dist. No. 216

Item 7, Film 182 6-13-55 et

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>D.C.</u>		COUNTY <u>47x-3</u>	
CITY (If outside corporate limits, write RURAL or and give nearest town) <u>Bethesda</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
X TOWN				OR TOWN			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital</u>				STREET ADDRESS (If rural give location) <u>3418 Hayfield St. N.W.</u>			
3. NAME OF DECEASED: (Type or Print) <u>Frank Michael McLaughlin</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>June 5 1955</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>March 24 1881</u>	
9. AGE last birthday <u>74</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Retired Merchant Marine Service</u>		11. BIRTHPLACE (State or foreign country): <u>Iowa</u>		12. CITIZEN OF WHAT COUNTRY: <u>U.S.</u>	
13. FATHER'S NAME: <u>Frank McLaughlin</u>				14. MOTHER'S MAIDEN NAME: <u>Margaret Burke</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY No. <u>34184 Hayfield St. N.W.</u>		17. INFORMANT'S ADDRESS: <u>Mrs. Sighe McLaughlin Wash. D.C.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
204.1 IMMEDIATE CAUSE (A) <u>Acute Myelogenous Leukemia</u> DUE TO							
ANTECEDENT CAUSE (S) (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 12 1955</u> , to <u>June 5, 1955</u> , that I last saw the deceased alive on <u>June 4, 1955</u> , and that death occurred at <u>6:10 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Sidney L. Bonar</u>		M.D. <u>3921 Ingomar St. Wash. D.C.</u>		DATE SIGNED <u>6/5/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5-8-55</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>		LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>6/7/55</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		24. FUNERAL DIRECTOR <u>James T. Ryan</u>		ADDRESS <u>317 Pa. Ave. S.E. Wash. D.C.</u>	

BUREAU V. S.

JUN 9 1955

RECEIVED

5698

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Mass.</u>	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) <u>17 Taberna Park</u>	LENGTH OF STAY (in this place) <u>12 days</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Roslindale 58X-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>25 Washington Sanitarium & Hospital</u>		STREET ADDRESS (If rural give location) <u>53 Augustus</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE OF DEATH: (Month) (Day) (Year)	
<u>Catherine ANN McNamee</u>		<u>6-5-1955</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>Caucasian</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widow</u>	8. DATE OF BIRTH: <u>3-7-1878</u>
9. AGE last birthday <u>77</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country): <u>Canada</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>John St. George</u>		14. MOTHER'S MAIDEN NAME: <u>McQuire</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT & ADDRESS: <u>Hospital Records</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Cerebral hemorrhage & Rheumatism</u>			<u>10 days</u>
ANTECEDENT CAUSE (S) (B) <u>Cerebral Arteriosclerosis</u>			<u>?</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>(260X)</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Diabetes Mellitus</u>			<u>20 yrs</u>
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>6/10</u> , 19 <u>55</u> , to <u>6/5</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>6/4</u> , 19 <u>55</u> , and that death occurred at <u>1:25</u> P. M. from the causes and on the date stated above.			
SIGNATURE <u>Dr. H. H. Wolcott, M.D.</u>		M. D. <u>500 Underwood St NW</u>	
DATE SIGNED <u>6-5-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>June 8, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>St. Josephs Cemetery</u>		LOCATION (City, town, or county) (State) <u>West Roxbury, Mass.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>June 5-1955</u>		REGISTRAR'S SIGNATURE <u>J. McKinnon</u>	
24. FUNERAL DIRECTOR <u>John J. Stalley</u>		ADDRESS <u>254 Carroll St NW</u>	
		<u>Taberna Park 12, D.C.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF HEALTH, EDUCATION & WELFARE
CERTIFICATE OF DEATH

BUREAU V. S.

JUN 7 1955

RECEIVED

5699

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Ind</u>		COUNTY <u>Montg</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>17 Takoma Park</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>75 Washington Sanitarium</u>		<u>+ H.O. Spital</u>		STREET ADDRESS (If rural give location) <u>7 Manchester Pl</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Mitchell</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>June 8 1955</u>			
5. SEX: <u>FE</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH: <u>6/8/55</u>	9. AGE last birthday: yrs. Months Days		IF UNDER 1 YEAR: Hours Min. <u>12 15</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>INFANT</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>NUNT</u>		11. BIRTHPLACE (State or foreign country): <u>WASH SANITARIUM TAKOMA PARK MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Joseph Philip Mitchell</u>				14. MOTHER'S MAIDEN NAME: <u>Barbara Inogene Fay</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.):		16. SOCIAL SECURITY No.		17. INFORMANT & ADDRESS: <u>Hosp. Records</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>PREMATURITY</u>							<u>12 HOURS</u>
ANTECEDENT CAUSE (S)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>NONE</u>							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6/8</u> , 19 <u>55</u> , to <u>6/8</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>6/8/55</u> , 19 <u>55</u> , and that death occurred at <u>8:15</u> M, from the causes and on the date stated above.							
SIGNATURE <u>George Pence</u>		ADDRESS <u>M.O. 927 Washington Sanitarium</u>		DATE SIGNED <u>6/8/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Cremation		6-10-55		The Washington San.&Hosp.		Takoma Park, Md.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
June 10-1955		<u>William Dodd</u>		<u>Ra Hare M.D.</u>		<u>Takoma Park, Md</u>	

2065273241
VS. A15 — 10-53

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

permission has been given by both parents

written permission has been given by both parents

BUREAU V. S.

JUN 13 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05775

5776

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Montgomery		MARYLAND		STATE District of Columbia			
CITY (If outside corporate limits, write RURAL OR and give nearest town) Bethesda Rural		LENGTH OF STAY (in this place) lmo 24 days		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington, D.C.		47X-3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Naval Hospital				STREET ADDRESS (If rural give location) 4808 45th Street, N.W.		✓	
3. NAME OF DECEASED: (First) Frederick (Middle) Jeann (Last) MOORE				4. DATE (Month) (Day) (Year) OF DEATH: June 5 19 55			
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: 3-6-91	9. AGE last birthday 64 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mariner		10B. KIND OF BUSINESS OR INDUSTRY: Mariner Retired		11. BIRTHPLACE (State or foreign country): New York		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME: Frederick MOORE				14. MOTHER'S MAIDEN NAME: Elizabeth JENSEN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk): Yes (If Yes, give war, or dates of service) WW I		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT & ADDRESS: Wife Mrs. Helen MOORE Same as above			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
141X IMMEDIATE CAUSE		(A) Tracheal Obstruction				1 hr	
ANTECEDENT CAUSE (S)		DUE TO					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.		(B) Metastases from				4 mos	
		DUE TO					
		(C) Concussion of the Tongue				1 yr	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: 26 Aug. 1954		19B. MAJOR FINDINGS OF OPERATION: Indurated lesion Rt. Side of Tongue				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 11 Apr. , 19 55 , to 5 June , 19 55 , that I last saw the deceased alive on 5 June , 19 55 , and that death occurred at 6:50 P.M. , from the causes and on the date stated above.							
SIGNATURE W. F. REID		MC USN U. S. Naval Hospital, NNMC, Bethesda, Maryland		ADDRESS		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 8 June 1955		NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		LOCATION (City, town, or county) (State) Arlington, Virginia	
DATE REC'D BY LOCAL REGISTRAR 5 June 1955		REGISTRAR'S SIGNATURE Mary E. Gravelly		24. FUNERAL DIRECTOR De Vol Funeral Home		ADDRESS 2224 Wisconsin Avenue, Washington, D.C.	

RECEIVED

JUN 13 1955

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05776

5777

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE --		COUNTY --	
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
X TOWN <u>Bethesda</u>		<u>63 days</u>		<u>Washington, D. C.</u> <u>47X-3</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>50 The Clinical Center Natl. Institutes of Health</u>				<u>1947 Capitol Ave. N.E.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>Landon Edward Moore</u>				<u>June 24 1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>M</u>	<u>N</u>	<u>Single</u>	<u>7 Sept. 1913</u>	<u>47</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Laborer</u>		<u>Railroad</u>		<u>Virginia</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Lewis Moore</u>				<u>Inez ?</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.		17. INFORMANT & ADDRESS:			
<u>No</u>		<u>225-05-4379</u>		<u>The medical record, The Clinical Center</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE							
(A) <u>Nephrosclerosis and uremia</u>							
ANTECEDENT CAUSE (S)							
(B) <u>Essential malignant hypertension</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<u>none</u>		<u>none</u>					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
<input type="checkbox"/>		<u>None</u>					
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
		<u>M.</u>					
22. I hereby certify that I attended the deceased from <u>Apr. 22, 1955</u> , to <u>June 24, 1955</u> , that I last saw the deceased alive on <u>June 24</u> , 19 <u>55</u> , and that death occurred at <u>3:44P</u> M, from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
<u>William L. Morgan</u>		<u>The Clinical Center</u>		<u>June 25, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>6-30-55</u>		<u>Lincoln Mem.</u>		<u>Suitland, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>6/27/55</u>		<u>Bessie M. Thompson</u>		<u>W. Ernest Jarrell</u>		<u>#178</u> <u>1432 3rd St. Wash. D.C.</u>	

BUREAU V. 3

JUN 30 1965

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05777

5778

CERTIFICATE OF DEATH

Reg. Dist. No. 215.....

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Louisiana</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
<u>Bethesda Rural</u>		<u>58 Days</u>		<u>New Orleans</u> <u>56X-3</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>U. S. Naval Hospital</u>				<u>300 Audubon Street</u>			
3. NAME OF DECEASED:		(First) (Middle) (Last)		4. DATE (Month) (Day) (Year)		OF DEATH	
<u>Aylmer</u>		<u>Lee</u>		<u>June</u>		<u>23</u> <u>1955</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>White</u>	<u>Divorced</u>	<u>6-19-90</u>	<u>65</u> yrs.	Months	Days	Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Mariner</u>		<u>Mariner</u>		<u>Arkansas</u>		<u>U.S.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Aylmer Lee MORGAN</u>				<u>Effie NEWTON</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
<u>Yes</u> <input checked="" type="checkbox"/> (If Yes, give war or dates of service) <u>WW I WW II</u>		<u>Unknown</u>		<u>Aylmer L. MORGAN III</u> <u>Same as above</u>			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
601X IMMEDIATE CAUSE				(A) <u>Pulmonary embolus</u>			
ANTECEDENT CAUSE (S)				(B) <u>Thrombophlebitis, both legs.</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				(C) <u>Post-operative hydrocephalus, left.</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
<u>Gastro-intestinal hemorrhage</u>				<u>24 days</u>			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
<u>18 May 1955</u>		<u>Infarct, right kidney, hydrocephalus, Lt.</u>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLCE (Home, farm, factory) OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>26 April 1955</u> , to <u>23 June 1955</u> , that I last saw the deceased alive on <u>23 June</u> , 1955, and that death occurred at <u>4:40 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>E. M. Tomlin</u>				ADDRESS DATE SIGNED			
E. M. TOMLIN LCDR MC USN U. S. Naval Hospital, NMMC, Bethesda, Maryland							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>6-27-55</u>		<u>Arlington National Cemetery</u>		<u>Arlington, Virginia</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
		<u>Mary C. Carrelly</u>		<u>B. A. Pumphrey Funeral Home</u>		<u>555 Wisconsin Ave., Bethesda, Md.</u>	

RECEIVED
JUN 27 1955
BUREAU V. S.

5779

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Olney</u>		<u>28</u>		OR TOWN <u>Rockville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>The Montgomery County General Hospital, Inc.</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH: <u>June 24 1955</u>			
<u>George Franklin Moulden</u>							
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>widowed</u>	8. DATE OF BIRTH: <u>April 24 1883</u>	9. AGE last birthday <u>72</u> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>painter</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Joseph Moulden</u>				14. MOTHER'S MAIDEN NAME: <u>Anne Brennan</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Hospital Records</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Carcinoma of colon</u>							<u>18 months</u>
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May</u> , 19 <u>55</u> , to <u>June 24</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>June 24</u> , 19 <u>55</u> , and that death occurred at <u>6:25 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>A. D. Brumby</u>				DATE SIGNED <u>M.D. Frank Spier</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>July 1-55</u>		NAME OF CEMETERY OR CREMATORY <u>St Marys</u>		LOCATION (City, town, or county) (State) <u>Rockville Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>6-29-55</u>		REGISTRAR'S SIGNATURE <u>Esther B Fowler</u>		24. FUNERAL DIRECTOR <u>R. L. Humphrey</u>		ADDRESS <u>1551 W. Ar. B. H. Pk.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUL 5 1955

RECEIVED

5700

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Virginia</u>		COUNTY <u>Arlington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
17 TOWN <u>Takoma Park</u>		58 days		OR TOWN <u>Arlington</u> 83x-3			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
25 <u>Washington Sanitarium & Hospital</u>				1513 North Rhodes St. ✓			
3. NAME OF DECEASED: (Type or Print)		(First) (Middle) (Last)		4. DATE (Month) (Day) (Year)		OF DEATH:	
<u>Ethel</u>		<u>Brewer</u> <u>Mower</u>		<u>6</u> <u>3</u> <u>1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Female</u>	<u>White</u>	<u>Married</u>	<u>2-24-87</u>	<u>68</u> yrs.	Months	Days	Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>				<u>Canada</u>		<u>United States</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>William Schurman</u>				<u>Eliza Leard</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.):		16. SOCIAL SECURITY NO. (If Yes, give war or dates of service)		17. INFORMANT & ADDRESS:			
<u>No</u>		<u>Unknown</u>		<u>Hospital Records</u>		<u>Wash. San. & Hosp.</u>	
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
170x IMMEDIATE CAUSE (A)				<u>Carcinoma - Metastatic - lungs & genital.</u> <u>nine mos.</u>			
ANTECEDENT CAUSE (S): (B)				<u>Broncho-pneumonia</u> <u>Terminal</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
<u>Aug. 1954</u>		<u>Carcinoma R. Breast.</u>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4-5</u> , 1955, to <u>6-3</u> , 1955, that I last saw the deceased alive on <u>6-2</u> , 1955, and that death occurred at <u>2:15 A.M.</u> from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
<u>Robert A. Hare</u>		<u>M. D. Takoma Park, Md.</u>		<u>6/3/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Removal</u>		<u>6/3/55</u>		<u>Arlington</u>		<u>VA</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>June 31955</u>		<u>William Dodd</u>		<u>C. R. Cline</u>		<u>By: C. M. Travis</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 6 1955

BUREAU V. S.

5780

CERTIFICATE OF DEATH

Reg. Dist. No. 217.....

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>X</u> TOWN <u>Olney</u>		LENGTH OF STAY (in this place) <u>20 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Derwood</u> <u>X</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Montgomery County General Hospital, Inc</u> <u>73</u>				STREET ADDRESS (If rural give location) <u>/</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>John Edwin Muncaster</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>June 27 19 55</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH: <u>9/29/69</u>	9. AGE last birthday <u>85</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Farmer</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>William Edwin Muncaster</u>				14. MOTHER'S MAIDEN NAME: <u>Hannah Smith Magruder</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Uremia</u>						1 month	
ANTECEDENT CAUSE (B) DUE TO <u>Benign prostatic hypertrophy with urinary obstruction</u>						2 years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>none</u>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1930</u> 19, to <u>June 27, 1955</u> that I last saw the deceased alive on <u>6/27/55</u> , 19, and that death occurred at: <u>3:30 a M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Wm R. Lintner</u>				ADDRESS <u>Rockville, Md</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>6-29-55</u>		NAME OF CEMETERY OR CREMATORY <u>Rockville Union</u>		LOCATION (City, town, or county) (State) <u>Rockville-Montg. - Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>6-27-55</u>		REGISTRAR'S SIGNATURE <u>Bertand B Lawley</u>		24. FUNERAL DIRECTOR <u>Robert A. Cummins</u>		ADDRESS <u>Bethesda - Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 2

JUN 29 1955

RECEIVED

5781

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>MONTGOMERY</u> MARYLAND	STATE <u>Maryland</u> COUNTY <u>Montgomery</u>		
CITY (If outside corporate limits, write RURAL or give nearest town) <u>56</u> TOWN <u>Silver Spring</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>56</u> <u>Silver Spring</u>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>50</u> <u>2803 Urbana Drive</u>	STREET ADDRESS (If rural give location) <u>1</u> <u>2803 Urbana Drive</u>		
3. NAME OF DECEASED: (First) (Middle) (Last) <u>SARAH ELIZABETH PEABODY</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>6</u> <u>15</u> <u>1955</u>	
5. SEX: <u>female</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>widowed</u>	8. DATE OF BIRTH: <u>July 31, 1882</u>
		9. AGE last birthday <u>72</u> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Homemaker -</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Own Home - retired</u>	11. BIRTHPLACE (State or foreign country): <u>Halifax, Nova Scotia</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME: <u>William Rennie</u>		14. MOTHER'S MAIDEN NAME: <u>Ellen Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT & ADDRESS: <u>Silver Spring, Md.</u> <u>Mrs. Wm. Edw. Thompson, 2803 Urbana Drive,</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Bronchopneumonia</u>			<u>6 hrs</u>
ANTECEDENT CAUSE (S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>Carcinoma Stomach</u>			<u>6 mos</u>
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>✓</u>			
19A. DATE OF OPERATION: <u>✓</u>		19B. MAJOR FINDINGS OF OPERATION <u>✓</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 1, 1955</u> , to <u>June 15, 1955</u> , that I last saw the deceased alive on <u>June 15, 1955</u> , and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Patricia Conroy-Jones</u>		ADDRESS <u>12026 Georgia Silver Spring</u> DATE SIGNED <u>6/16/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Transit & burial</u>		<u>June 16, 1955</u>	
<u>Braman Cemetery, Newport, Newport County, Rhode Island</u>			
DATE REC'D BY LOCAL REGISTRAR <u>6-18-55</u>		REGISTRAR'S SIGNATURE <u>Frances Ellen Warner</u>	
24. FUNERAL DIRECTOR		ADDRESS	
<u>Wm. E. Pumphrey</u>		<u>Silver Spring, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 20 1955

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5782

CERTIFICATE OF DEATH

Reg. Dist. No. 216

05782

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>D. C.</u>	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Bethesda</u>	LENGTH OF STAY (in this place) <u>33 days</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Washington</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>The Clinical Center</u>	STREET ADDRESS (If rural give location) <u>1740 Euclid St. N. W.</u>		
3. NAME OF DECEASED: (Type or Print)		4. DATE OF DEATH: (Month) (Day) (Year)	
<u>William Henry Peter</u>		<u>June 18 19 55</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>April 16, 1921</u>
9. AGE last birthday <u>34</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Truck Driver</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Unknown</u>	
11. BIRTHPLACE (State or foreign country): <u>District of Columbia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>George Peter</u>		14. MOTHER'S MAIDEN NAME: <u>Bessie Jackson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-05-9504</u>	
17. INFORMANT & ADDRESS: <u>The medical record, The Clinical Center</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
442X IMMEDIATE CAUSE			
(A) <u>Arteriular Nephrosclerosis and veinia</u>			
ANTECEDENT CAUSE (S)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(B) <u>Hypertensive congestive heart failure</u>			
(C) <u>Essential hypertension</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>June 2, 1955</u>		19B. MAJOR FINDINGS OF OPERATION: <u>Superficial femoral ligation - no clots.</u>	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>none</u>	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) (Minute) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 16</u> , 19 <u>55</u> , to <u>June 18</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>June 18</u> , 19 <u>55</u> , and that death occurred at <u>6:40A</u> M, from the causes and on the date stated above.			
SIGNATURE <u>William L. Morgan</u>		DATE SIGNED <u>June 18, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		NAME OF CEMETERY OR CREMATORY <u>Lincoln Mem.</u>	
DATE THEREOF <u>6-21-55</u>		LOCATION (City, town, or county) (State) <u>Suitland, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>6/20/55</u>		24. FUNERAL DIRECTOR <u>Amrose B. Boyd</u>	
REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		ADDRESS	

BUREAU V. S.

JUN 22 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5783

CERTIFICATE OF DEATH

Reg. Dist. No. 24

05783

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>56 Silver Spring</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>000</u>				STREET ADDRESS (If rural give location) <u>804 Forston Dr.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Lena P Phillips</u>				4. DATE OF DEATH: (Month) (Day) (Year) <u>Jun. 12, 1955</u>			
5. SEX: <u>F.</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Widow</u>	8. DATE OF BIRTH: <u>Aug 25, 1876</u>	9. AGE last birthday <u>78</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Martinsburg. W. Va.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>William Roberts</u>				14. MOTHER'S MAIDEN NAME: <u>Eliza Cushwa</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Mrs Minnie Stoddard</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>420.0 Coronary Thrombosis</u>						<u>2 hours</u>	
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>Arteriosclerotic Heart Disease</u>						<u>8 years</u>	
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April, 1947</u> to <u>June 12, 1955</u> , that I last saw the deceased alive on <u>June 5, 1955</u> , and that death occurred at <u>10:10</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Robert B. Jones</u>		M. D. <u>7105 Riggs Rd.</u>		DATE SIGNED <u>6-12-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>6-15-55</u>		NAME OF CEMETERY OR CREMATORY <u>Glenwood</u>		LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>6-14-55</u>		REGISTRAR'S SIGNATURE <u>Frances Potter</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. L. L. L. L.</u>		ADDRESS <u>300 - 4th St N.E. Washington D.C.</u>	

RECEIVED

JUN 16 1955

BUREAU V. S.

5784

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>D.C.</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Bethesda</u>		LENGTH OF STAY (in this place) <u>15 Hours</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Washington</u> <u>47x3</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban</u>				STREET ADDRESS (If rural give location) <u>1817 Plymouth St. N.W.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>James Francis Pierce</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>June 10 1955</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>May 16, 1889</u>	9. AGE last birthday <u>66</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Patent Lawyer</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Michigan</u>		11. BIRTHPLACE (State or foreign country): <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Harvey C. Pierce</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Breau</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>yes</u> (If Yes, give war or dates of service) <u>World War</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Mrs. Beth Pierce 1817 Plymouth St. N.W. Washington D.C.</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Cerebral Thrombosis</u> DUE TO <u>12 days</u>							
ANTECEDENT CAUSE (B) <u>Cardio-vascular-renal disease</u> DUE TO <u>2 yrs</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 29, 1955</u> , to <u>June 10, 1955</u> , that I last saw the deceased alive on <u>June 10, 1955</u> , and that death occurred at <u>10:10 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Sigurd L. Bouvaris</u>		ADDRESS <u>M. 3925 Wisconsin 4424 2600 6/11/55</u>		DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>JUNE 14, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L CEM.</u>		LOCATION (City, town, or county) (State) <u>ARLINGTON, VIRGINIA</u>	
DATE REC'D BY LOCAL REGISTRAR <u>6/13/55</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		24. FUNERAL DIRECTOR <u>H. H. Jones Co.</u>		ADDRESS <u>Washington, D.C.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

STATE OF MARYLAND
DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

MADE IN MARYLAND

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE

INTERMEDIATE CAUSE

UNDERLYING CAUSE

PERMANENT CAUSE

TEMPORARY CAUSE

ACUTE CAUSE

CHRONIC CAUSE

INFECTIOUS CAUSE

NON-INFECTIOUS CAUSE

TRAUMATIC CAUSE

TOXIC CAUSE

CONGENITAL CAUSE

ACQUIRED CAUSE

HEREDITARY CAUSE

ENVIRONMENTAL CAUSE

DIETARY CAUSE

CLIMATE CAUSE

STRESS CAUSE

EXERCISE CAUSE

REST CAUSE

SLEEP CAUSE

WAKE CAUSE

FEELING CAUSE

THOUGHT CAUSE

ACTION CAUSE

REACTION CAUSE

BUREAU V. S.

JUN 15 1955

RECEIVED

5785

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Montgomery		MARYLAND		STATE S. Carolina		COUNTY --	
CITY (If outside corporate limits, write RURAL OR TOWN) Bethesda		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Whitmire, S. Carolina			
HOSPITAL OR INSTITUTION OR STREET ADDRESS The Clinical Center Nat'l Inst. of Health				STREET ADDRESS (If rural give location) 306 S. Church St.			
3. NAME OF DECEASED: (Type or Print) Clarence Victor Reed				4. DATE (Month) (Day) (Year) OF DEATH: June 8, 1955			
5. SEX: Male	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH: 10 Aug. 1919	9. AGE last birthday 35 yrs.	IF UNDER 1 YEAR Months 7 Days 28	IF UNDER 24 HRS. Hours Mln. 	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper		10B. KIND OF BUSINESS OR INDUSTRY: General contracting		11. BIRTHPLACE (State or foreign country): South Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Francis Reed				14. MOTHER'S MAIDEN NAME: Brama Rector			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes		16. SOCIAL SECURITY NO. (If Yes, give war or dates of service) W.W. II 247-10-0292		17. INFORMANT & ADDRESS: The Medical Record, The Clinical Center			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Severe pulmonary congestion							
ANTECEDENT CAUSE (S) DUE TO (B) Congenital heart disease, interatrial septal defect							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: 6/7/55		19B. MAJOR FINDINGS OF OPERATION: Interatrial septal defect				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) --		21C. WHERE DID (City or town) INJURY OCCUR? --		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY --		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? --			
22. I hereby certify that I attended the deceased from May 9, 1955 to June 8, 1955 , that I last saw the deceased alive on June 8, 1955 , and that death occurred at 4:35 AM , from the causes and on the date stated above.							
SIGNATURE George O. Kaiser		M. D. The Clinical Center, NIH				DATE SIGNED 6/8/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Transit-burial		DATE THEREOF 6-9-55		NAME OF CEMETERY OR CREMATORY Whitmire Cemetery		LOCATION (City, town, or county) (State) Newberry Co., So. Carolina	
DATE REC'D BY LOCAL REGISTRAR 6/10/55		REGISTRAR'S SIGNATURE Bessie M. Thompson		24. FUNERAL DIRECTOR Robert A. Humphrey		ADDRESS Bethesda, Md.	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUN 13 1955

RECEIVED

5786

05786

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>DC</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>X</u> TOWN <u>Kensington</u>		LENGTH OF STAY (in this place) <u>6 mo</u>		CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>Washington</u>		<u>47X-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Kensington Gardens Nursing Home</u>				STREET ADDRESS (If rural, give location) <u>2855 29th St.</u>			
3. NAME OF DECEASED:		(First) <u>Paul</u>		(Middle) <u>Lyon</u>		(Last) <u>Reed</u>	
(Type or Print)				4. DATE OF DEATH		June 30 1955	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR		
<u>Male</u>	<u>White</u>	<u>married</u>	<u>8-25-72</u>	<u>82</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Paul surgeon 21st A.</u>		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Ill</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Myron W. Reed</u>				14. MOTHER'S MAIDEN NAME: <u>Louise Lyon</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>yes</u>		16. SOCIAL SECURITY No.: <u>?</u>		17. INFORMANT & ADDRESS: <u>Nursing Home Records</u>			
(If Yes, give war or dates of service)							
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
334x Immediate cause (a) <u>Acute Cardiac Failure</u>							<u>24 hrs</u>
DUE TO							
(904.7) Antecedent cause(s) (b) <u>Fracture left hip</u>							<u>2-21-55</u>
Diseases or conditions, if any, giving rise to the above cause DUE TO							
stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Cerebral sclerosis</u>							<u>1 yr.</u>
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town)		(County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Frank J. Bruchant</u>				M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>6-30-55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>July 1, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
DATE REC'D BY LOCAL REG. <u>6/30/55</u>		REGISTRAR'S SIGNATURE <u>Jessie M. Thompson</u>		24. FUNERAL DIRECTOR <u>Robert C. Humphrey</u>		ADDRESS <u>Bethesda, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 5 1955

BUREAU VI 51

Reg. Dist. No. 215

7557 Wisconsin Ave. Bethesda, Md.

VS. A15 — 10 - 53

BUREAU V. S.

JUN 28 1955

RECEIVED

5788

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Silver Spring</u> <u>56</u>			
X TOWN <u>Bethesda</u>		<u>9 days</u>		STREET ADDRESS (If rural give location) <u>8403 Dixon Ave.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>The Clinical Center</u>				50 <u>Natl. Institutes of Health</u>			
3. NAME OF DECEASED: (First) <u>Mary</u>		(Middle) <u>Lou</u>		(Last) <u>Ridgeway</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>June 3 1955</u>	
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>February 26, 1932</u>		9. AGE last birthday <u>23</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>--</u>		11. BIRTHPLACE (State or foreign country): <u>Mississippi</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Charles Forni</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Holladay</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-30-2614</u>		17. INFORMANT & ADDRESS: <u>The medical record, The Clinical Center</u>			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
434.4 Undiagnosed heart disease and rheumatoid							
IMMEDIATE CAUSE (A) <u>arthritis</u>							
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>--</u>		19B. MAJOR FINDINGS OF OPERATION <u>--</u>					
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? <u>--</u>			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>--</u>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>--</u>			
22. I hereby certify that I attended the deceased from May 25, 1955, to June 3, 1955 that I last saw the deceased alive on <u>June 3 1955</u> and that death occurred at <u>6:10a M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Eagle Silver M.D.</u>		ADDRESS <u>The Clinical Center</u> DATE SIGNED <u>for Thomas D. Stevenson, M.D. Natl. Institutes of Health</u>					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>6-6-55</u>		NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>		LOCATION (City, town, or county) (State) <u>Arlington Va.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>6/6/55</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		24. FUNERAL DIRECTOR <u>Warner E. Thompson</u>		ADDRESS <u>8454 Georgia Ave Silver Spring Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUN 8 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05789

5789

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>District of Columbia</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
<u>Bethesda Rural</u>		<u>15 days</u>		<u>Washington</u>		<u>47X-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS			
<u>U. S. Naval Hospital</u>				<u>429 Valley Ave., S.E.</u>			
3. NAME OF DECEASED: (Type or Print)		(First) (Middle) (Last)		4. DATE (Month) (Day) (Year)			
<u>Frances Jane</u>		<u>ROBERTS</u>		DEATH: <u>June 30</u> <u>19 55</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Female</u>	<u>White</u>	<u>Married</u>	<u>April 5, 1921</u>	<u>34 yrs.</u>	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>				<u>Missouri</u>		<u>U.S.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Wilson Lee Overall</u>				<u>Marion Brown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		(If Yes, give war or dates of service)		17. INFORMANT & ADDRESS:			
<u>Yes</u>		<u>WW II</u>		<u>429 Valley Ave., S.E.</u> <u>Derwood Roberts Washington, D. C.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Hodgkin's Disease</u>						<u>2 yrs.</u>	
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
		M.					
22. I hereby certify that I attended the deceased from <u>15 June, 1955</u> , to <u>30 June, 1955</u> , that I last saw the deceased alive on <u>30 June, 1955</u> , and that death occurred at <u>1:55pm</u> , from the causes and on the date stated above.							
SIGNATURE <u>Plitman</u>				ADDRESS		DATE SIGNED	
<u>G. I. PLITMAN, LT. MC, USNR, U. S. Naval Hospital, NMMC, Bethesda, Maryland</u>				<u>6-30-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>7-2-55</u>		<u>Forest Hill Cemetery</u>		<u>Kansas City, Missouri</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
		<u>Mary E. Parselle</u>		<u>S. H. HINES</u>		<u>2901 14th St., SE, Wash., D.C.</u>	

RECEIVED

JUL 1 1955

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05790

5790

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Montgomery		MARYLAND		STATE Virginia		COUNTY Arlington	
CITY (If outside corporate limits, write RURAL or town and give nearest town) Bethesda Rural		LENGTH OF STAY (in this place) 2mo 4 days		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Arlington			
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Naval Hospital				STREET ADDRESS (If rural give location) 102 North Garfield			
3. NAME OF DECEASED: (First) Fred (Middle) Thomas (Last) ROSE				4. DATE (Month) (Day) (Year) OF DEATH: June 8 1955			
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed	8. DATE OF BIRTH: 1-22-81	9. AGE last birthday 74 yrs.	IF UNDER 1 YEAR: Months	IF UNDER 24 HRS.: Days	IF UNDER 24 HRS.: Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Guard				10B. KIND OF BUSINESS OR INDUSTRY: U. S. Government		11. BIRTHPLACE (State or foreign country): Virginia	
13. FATHER'S NAME: George C. ROSE				12. CITIZEN OF WHAT COUNTRY? US			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes (If Yes, give year or dates of service) Spanish American				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT'S ADDRESS: Daughter Mrs. Thelma L. STORM Same as above	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) multiple myeloma						months.	
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. wide spread atherosclerosis						yes.	
19A. DATE OF OPERATION: 2		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 4 May , 1955, to 8 Jun , 1955, that I last saw the deceased alive on 8 Jun , 1955, and that death occurred at 11:45 PM from the causes and on the date stated above.							
SIGNATURE A. J. CAPPELLATTI				ADDRESS LT MC USN U. S. Naval Hospital, NMHC, Bethesda, Maryland		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 11 June 1955		NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		LOCATION (City, town, or county) (State) Washington, D.C.	
DATE REC'D BY LOCAL REGISTRAR 9 June 1955		REGISTRAR'S SIGNATURE Mary E. Capellatti		24. FUNERAL DIRECTOR Lee Funeral Home		ADDRESS 4th and Mass. Ave., Washington, D.C.	

BUREAU V. S.

JUN 14 1955

RECEIVED

5701
CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Montgomery	MARYLAND	STATE md.	COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) 17 Takoma Park	LENGTH OF STAY (In this place) 2 days	CITY (If outside corporate limits, write RURAL and give nearest town) 17 Takoma Park	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 75 Washington Sanitarium & Hospital		STREET ADDRESS (If rural give location) 8608 Flower Ave. Marlene Apt. D-5	
3. NAME OF DECEASED: (First) (Middle) (Last) Harry Marcus Rubens		4. DATE (Month) (Day) (Year) OF DEATH: 6 - 26 - 1955	
5. SEX: male	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married	8. DATE OF BIRTH: 4-8-87
9. AGE last birthday 68 yrs.		10. BIRTHPLACE (State or foreign country): New York	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): pharmacist		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Jacob Rubens		14. MOTHER'S MAIDEN NAME: Sarah Bawmer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): no		16. SOCIAL SECURITY NO.: UNKNOWN	
17. INFORMANT & ADDRESS: Hospital Record			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) 454X Congestive Cardiac Failure			Terminal
ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. 260X Thrombosis Right Coronary Artery			48 hours
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Hypertension, Diabetes Mellitus			years
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, office bldg., etc.) OF INJURY	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from June 2, 1955 , to June 26, 1955 , that I last saw the deceased alive on June 26, 1955 , and that death occurred at 11:00 P.M. from the causes and on the date stated above.			
SIGNATURE Robert A. Hare		ADDRESS Takoma Park, Md. DATE SIGNED 6/27/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 6/29/55	
NAME OF CEMETERY OR CREMATORY WASH NATL		LOCATION (City, town, or county) (State) SUITLAND MD	
DATE REC'D BY LOCAL REGISTRAR June 28 1955		REGISTRAR'S SIGNATURE J. William Dodd	
24. FUNERAL DIRECTOR W.W. Chambers Co - Riverdale, Md		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 1

JUN 30 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5732

CERTIFICATE OF DEATH

Reg. Dist. No.

05792 223

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Montgomery</i>		MARYLAND		STATE <i>D.C.</i>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>17 Takoma Park.</i>		LENGTH OF STAY (in this place) <i>5 days</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>438 Riggs Rd. - N.E. Wash. D.C.</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>75 Wash. San. & Hosp.</i>				STREET ADDRESS (If rural give location) <i>438 Riggs rd.</i>		<i>47x3</i>	
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
<i>Nathan (None) Rubin</i>				<i>June - 17 1955</i>			
5. SEX: <i>M</i>	6. COLOR OR RACE: <i>Jewish</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <i>married</i>	8. DATE OF BIRTH: <i>5-18-82</i>	9. AGE last birthday <i>73</i> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Paper hanger</i>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <i>Russia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME: <i>Joseph Rubin</i>				14. MOTHER'S MAIDEN NAME: <i>Sarah (unknown to pt.)</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>		16. SOCIAL SECURITY NO. (If Yes, give war or dates of service)		17. INFORMANT & ADDRESS: <i>728 Ogdenhorpe St. N.E. Son - Mr. Henry Rubin Wash. D.C.</i>			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.0 IMMEDIATE CAUSE				Hypertensive-arteriosclerotic heart disease with decompensation		INTERVAL BETWEEN ONSET AND DEATH <i>6 mos.</i>	
ANTECEDENT CAUSE (S)				DUE TO <i>a. Senile deterioration (cerebral)</i>		<i>3 mos.</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST				DUE TO			
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Arteriosclerotic gangrene, legs</i>							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>January, 1954</i> , to <i>June</i> , 1955, that I last saw the deceased alive on <i>June 17</i> , 1955, and that death occurred at <i>8:30 P.M.</i> , from the causes and on the date stated above.							
SIGNATURE <i>Stanley W. Kistner</i>		M. D. <i>1835 Eye St. N.W.</i>		DATE SIGNED <i>June 17, 1955</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>6/19/55</i>		NAME OF CEMETERY OR CREMATORY <i>Das Israel Cemetery</i>		LOCATION (City, town, or county) (State) <i>Wash D.C.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>June 18 1955</i>		REGISTRAR'S SIGNATURE <i>William Dodd</i>		24. FUNERAL DIRECTOR <i>Soldberg</i>		ADDRESS <i>Home Wash D.C.</i>	

CERTIFICATE OF DEATH

STATE OF NEW YORK

County of ...

City of ...

On the ... day of ... 1955

at ...

I, the undersigned, a duly qualified ...

do hereby certify that ...

... was born ...

... died ...

... was buried ...

... at ...

... by ...

... in ...

... at ...

... on ...

... at ...

... by ...

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BUREAU V. 3

JUN 20 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5791

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05793

Reg. Dist.

No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>DC</u>		COUNTY <u>47X-3</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Bethesda</u>		LENGTH OF STAY (in this place) <u>3 hrs</u>		CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>Washington</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>74 Suburban Hosp</u>				STREET ADDRESS (If rural, give location) <u>4412 44th N.W.</u>			
3. NAME OF DECEASED: (Type or Print) (First) (Middle) (Last) <u>Robert - ALLEN - Rudolph</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>6 - 11 1955</u>			
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH: <u>Aug. 10, 1934</u>	9. AGE last birthday: <u>18</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>high school</u>		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Wash. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Malton L. Rudolph</u>				14. MOTHER'S MAIDEN NAME: <u>Winnon Kiser</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY No.: <u>yes</u>		17. INFORMANT & ADDRESS: <u>3215 Maryland Ave. N.W. Wash. D.C. 20018</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
825X Immediate cause (a) <u>Cerebral hemorrhage</u> DUE TO Antecedent cause(s) (b) <u>fracture of skull</u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)						4 hrs.	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>fracture left femur & R. shoulder</u>							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>highway</u>		21c. (City or town) (County) (State) <u>Silverdale Montg 15 Md</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>6-11-55 2:15 AM</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>driver in auto accident</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Frank J. Brosschant</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/> <u>6-11-55</u>					
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>6/11/1955</u>		NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		LOCATION (City, town, or county) (State) <u>Swirland Md.</u>	
DATE REC'D BY LOCAL REG. <u>6/13/55</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		24. FUNERAL DIRECTOR <u>W. W. CHAMBERS CO., Washington, D.C.</u>		ADDRESS	

RECEIVED

JUN 15 1955

BUREAU V. S.

5703

CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Montgomery</i>		MARYLAND		STATE <i>Dist. of Col.</i>		COUNTY	
CITY (If outside corporate limits, write and give nearest town)		RURAL		CITY (If outside corporate limits, write and give nearest town)		OR	
TOWN <i>Takoma Park</i>		LENGTH OF STAY (in this place) <i>33 days</i>		TOWN <i>Wash., D.C.</i>		<i>47X-3</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Washington Sanitarium and Hospital</i>				STREET ADDRESS (If rural give location) <i>7113 Georgia Ave</i>			
3. NAME OF DECEASED: (First) (Middle) (Last) <i>Edith — Ruth</i>				4. DATE (Month) (Day) (Year) OF DEATH: <i>June 4th 1955</i>			
5. SEX: <i>Female</i>		6. COLOR OR RACE: <i>White</i>		7. SINGLE. MARRIED. WIDOWED. DIVORCED. (Specify) <i>Married</i>		8. DATE OF BIRTH: <i>6/1/1878</i>	
9. AGE last birthday <i>77</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		11. BIRTHPLACE (State or foreign country): <i>Germany</i>		12. CITIZEN OF WHAT COUNTRY? <i>German</i>	
13. FATHER'S NAME: <i>Nathan Herman</i>				14. MOTHER'S MAIDEN NAME: <i>Loeb</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.		17. INFORMANT & ADDRESS: <i>Hospital Record</i>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <i>Congestive Heart Failure</i>						<i>Sudden</i>	
DUE TO (B) <i>Chronic Myocarditis</i>						<i>23 yrs.</i>	
DUE TO (C) <i>Femur Fracture (Introductory)</i>						<i>5/3/55</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <i>5/4/55</i>				19B. MAJOR FINDINGS OF OPERATION: <i>Fracture of left femur (Hep. pathology)</i>			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.) <i>Home</i>		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? <i>7113 Georgia Ave. Wash. D.C.</i>			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: <i>5/3/55 2 P.M.</i>		21E. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input checked="" type="checkbox"/> at work		21F. HOW DID INJURY OCCUR? <i>Fell in Kitchen</i>			
22. I hereby certify that I attended the deceased from <i>6/3/55</i> , to <i>6/4/55</i> , that I last saw the deceased alive on <i>6/3/55</i> , and that death occurred at <i>8:25</i> M., from the causes and on the date stated above.							
SIGNATURE <i>J. H. Morse</i>				ADDRESS <i>7030 Carroll Ave Takoma Park Md.</i>		DATE SIGNED <i>6/4/55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>6-7-55</i>		NAME OF CEMETERY OR CREMATORY <i>Met Lebanon Cem</i>		LOCATION (City, town, or county) (State) <i>Md. Pr. George</i>	
DATE REC'D BY LOCAL REGISTRAR <i>June 5 1955</i>		REGISTRAR'S SIGNATURE <i>J. H. Morse</i>		24. FUNERAL DIRECTOR <i>B. Ranganathan & Son 5501-14 St NW</i>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUN 7 1955

RECEIVED

5792

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>District of Columbia</u> COUNTY			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Bethesda</u>		12 days		TOWN <u>Washington</u> 47X-3			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
50 The Clinical Center				1014 17th Place, N.E.			
3. NAME OF DECEASED:		(First) (Middle) (Last)		4. DATE OF DEATH:			
(Type or Print) <u>Margaret</u>		<u>B. Rutledge</u>		June 26 1955			
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH:	
F		W		Married		July 30, 1902	
9. AGE last birthday:		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
52 yrs.		Months 10		Days 26		Hours Min.	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): <u>Reg. Nurse</u>				10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
						Sweden	
12. CITIZEN OF WHAT COUNTRY?				U.S.A.			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Albert Ahlstrom</u>				<u>Anna Anderson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:	
No				577-52-8670		The medical record, The Clinical Center	

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Interval Between Onset And Death	
156.1 Immediate cause		4 min	
(a) <u>Angiosarcoma of liver</u>			
Antecedent causes (s)			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.			
(b) <u>Cholestasis of liver</u>		254	
(c) <u>Throat and neck infection</u>		23 yr	

11. OTHER SIGNIFICANT CONDITIONS				Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION			
2. 8				0			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY)	
None		None					
TIME (Month) (Day) (Year) (Hour)		INJURY OCCURRED		HOW DID INJURY OCCUR?			
OF INJURY		While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					

22. I hereby certify that I attended the deceased from June 14, 1955, to June 26, 1955, that I last saw the deceased alive on June 26, 1955, and that death occurred at 11 AM, from the causes and on the date stated above.

SIGNATURE		(Degree or title)		ADDRESS		DATE SIGNED	
<u>Rester M. Crawford MD</u>				The Clinical Center			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		6-29-55		Ft. Lincoln Cemetery		Prince George Co. Md	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
6/27/55		<u>Bessie M. Thompson</u>		<u>Robert W. Humphrey</u>		Bethesda, Md.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 1

JUN 20 1965

RECEIVED
FBI

5793

CERTIFICATE OF DEATH

Reg. Dist. No. 217...

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Montgomery</u>
CITY (If outside corporate limits, write RURAL or and give nearest town) <u>X</u> TOWN <u>Olney</u>	LENGTH OF STAY (in this place) <u>6</u> days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Poolesville</u> <u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Montgomery County General Hospital, Inc.</u>		STREET ADDRESS (If rural give location) <u>/</u>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <u>Lorenzo</u>	(Middle) <u>Dowe</u>	(Last) <u>Sager</u>	
(Type or Print)		OF DEATH: <u>June</u> <u>26</u> 19 <u>55</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH: <u>10/12/70</u>
9. AGE last birthday <u>84</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Carpenter</u>		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Amos Sager</u>		14. MOTHER'S MAIDEN NAME: <u>Jessie Irene Good</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: <u>Hospital Record</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE <u>443X</u>		
(A) DUE TO <u>Congestive heart failure</u>		<u>1 month</u>
ANTECEDENT CAUSE (S)		
(B) DUE TO <u>Hypertension</u>		<u>10 yr</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.		
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION: <u>0</u>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6/23, 1955, to 6/26, 1955, that I last saw the deceased alive on 6/26/55, 1955, and that death occurred at 3:30 PM, from the causes and on the date stated above.

SIGNATURE <u>S. D. Brummett</u>	ADDRESS <u>M. D. Sandy Spring, Md.</u>	DATE SIGNED <u>6/26/55</u>
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>6-30-55</u>	NAME OF CEMETERY OR CREMATORY <u>Hammon Run, Md.</u>
DATE REC'D BY LOCAL REGISTRAR <u>6-26-55</u>	REGISTRAR'S SIGNATURE <u>Esther B. L. L. L.</u>	24. FUNERAL DIRECTOR <u>Robert A. Brummett</u>
		ADDRESS <u>Bethesda, Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 29 1955

BUREAU V. 2

CERTIFICATE OF DEATH

Reg. Dist. No. 216

5794

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>MONTGOMERY</u>	MARYLAND	STATE <u>WASHINGTON</u>	COUNTY <u>D.C.</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>WASHINGTON, D.C. 47K-3</u>	
X TOWN <u>BETHESDA, MD.</u>	<u>15 HOURS</u>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>SUBURBAN HOSPITAL BETHESDA 14, MD.</u>		STREET ADDRESS (If rural give location) <u>4425 WISCONSIN AVE., NW</u>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year) OF DEATH:	
(First) <u>MARGARENA</u>	(Middle) <u>M. (?)</u>	(Last) <u>SCHOLL</u>	<u>6 / 4 1955</u>
5. SEX: <u>FEMALE</u>		6. COLOR OR RACE: <u>WHITE</u>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>WIDOWED</u>		8. DATE OF BIRTH: <u>Sept. 22, 1892</u>	
9. AGE last birthday: <u>62</u> yrs.		IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>HOUSE WIFE.</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>HOME.</u>	
11. BIRTHPLACE (State or foreign country): <u>POLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>?</u>		14. MOTHER'S MAIDEN NAME: <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.): <u>NO</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>3ielinski</u>	
17. INFORMANT & ADDRESS: <u>4425 WISCONSIN AVE, NW</u>		MARJORIE B. SCATES, DAUGHTER.	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) <u>420.0 ACUTE PULMONARY CONGESTION.</u>		<u>15 HRS.</u>
DUE TO		
ANTECEDENT CAUSE (B) <u>ACUTE CONGESTIVE HEART FAILURE</u>		<u>20 HRS.</u>
DUE TO		
(C) <u>ARTERIOSCLEROTIC HEART DISEASE.</u>		<u>2 YRS.</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>GENERALIZED ARTERIOSCLEROSIS</u>		<u>20 YRS.</u>
19A. DATE OF OPERATION: <u>2</u>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <u>2/15</u> , 19 <u>55</u> , to <u>6/4</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>6/4</u> , 19 <u>55</u> , and that death occurred at <u>9:45</u> P.M., from the causes and on the date stated above.		
SIGNATURE <u>Signeur Greenbaum</u>		DATE SIGNED <u>6/4/55</u>
M.D. <u>9300 Ewing Dr. BETHESDA MD</u>		
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF <u>6/8/55</u>	NAME OF CEMETERY OR CREMATORY <u>Congressional</u>
		LOCATION (City, town, or county) <u>Washington D.C.</u>
DATE REC'D BY LOCAL REGISTRAR <u>6/6/55</u>	REGISTRAR'S SIGNATURE <u>Bernie M. Thompson</u>	24. FUNERAL DIRECTOR <u>The S. H. Newer Co. 2901 K St. NW</u>

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUN 8 1955

RECEIVED

5795

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Turkey</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
<u>X</u> TOWN <u>Bethesda</u> Rural		<u>43</u> days		TOWN <u>Istanbul</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Naval Hospital</u>				STREET ADDRESS (If rural give location) <u>Apt. Daire 3, Sisli, Istanbul</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>IFTIHAR (N) SEVAND</u>				<u>June 24 1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>White</u>	<u>Single</u>	<u>2-11-52</u>	<u>3</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Mariner</u>			10B. KIND OF BUSINESS OR INDUSTRY: <u>Mariner</u>		11. BIRTHPLACE (State or foreign country): <u>Turkey</u>		12. CITIZEN OF WHAT COUNTRY? <u>Turkey</u> ✓
13. FATHER'S NAME: <u>Hikmet (N) SEVAND</u>				14. MOTHER'S MAIDEN NAME: <u>Guler USTER</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS: <u>Father Hikmet (N) SEVAND Turkish Navy 5211 Wilson Lane, Bethesda, Maryland</u>		
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
754.4 IMMEDIATE CAUSE (A) <u>Congestive Cardiac failure</u>						<u>6 months</u>	
ANTECEDENT CAUSE (S) (B) <u>Congenital Heart Disease - probably</u>						<u>Since birth</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. <u>Intra-auricular septal defect</u>							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12 May, 1955</u> , to <u>24 June, 1955</u> that I last saw the deceased <u>live on 24 June, 1955</u> , and that death occurred at <u>0735 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>T. E. Cone, Jr.</u>				ADDRESS <u>U. S. Naval Hospital, NMMC, Bethesda, Maryland</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>6-24-55</u>		NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>		LOCATION (City, town, or county) (State) <u>Montgomery County, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>6-24-55</u>		REGISTRAR'S SIGNATURE <u>Mary E. Russell</u>		24. FUNERAL DIRECTOR <u>W. A. Pumphrey Funeral Home</u>		ADDRESS <u>7551 Wisconsin Ave., Bethesda, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 27 1955
BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06895

5796

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Boysds</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
00				<u>R.F.D. Boysds</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
(Type or Print) <u>MARTHA E. SHAW</u>				DEATH: <u>June 30, 1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Female</u>	<u>White</u>	<u>Widowed</u>	<u>April 27, 1892</u>	<u>63</u> yrs.	Months <u>2</u> Days <u>3</u>	Hours <u></u> Min. <u></u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>Own Home</u>		<u>Maryland</u>		<u>US</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Charles F. Ricketts</u>				<u>Alice Ricketts</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.		17. INFORMANT & ADDRESS:	
<u>No</u>				<u>None</u>		<u>Ervin Ricketts-R.F.D. Rockville.Md.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE						<u>3 month</u>	
(A) <u>Myocarditis, with congestive Heart Fail.</u>							
ANTECEDENT CAUSE (S)						<u>40 years</u>	
(B) <u>Rheumatic Heart disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
0							
20. AUTOPSY?							
YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec 1954</u> to <u>30 June 1955</u> , that I last saw the deceased alive on <u>29 June 1955</u> , and that death occurred at <u>9:15 AM</u> , from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
<u>Gordon M. Smith</u>		<u>Boysds</u>		<u>30 June 55</u>			
M. D.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>7-3-55</u>		<u>Potomac Church Cem.</u>		<u>Potomac, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>7-12-55</u>		<u>Beattie M. Thompson</u>		<u>Robert A. Thompson</u>		<u>Bethesda, Md.</u>	

BUREAU V. 81

JUL 18 1955

RECEIVED

5797

CERTIFICATE OF DEATH

Reg. Dist. No. 516

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Montgomery	MARYLAND	STATE Maryland	COUNTY Montgomery
CITY (If outside corporate limits, write RURAL OR and give nearest town) X TOWN Chevy Chase	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Chevy Chase	X
HOSPITAL OR INSTITUTION OR STREET ADDRESS 7214 Delfield Street		STREET ADDRESS (If rural give location) 7214 Delfield Street	1
3. NAME OF DECEASED: (First) (Middle) (Last) George Reed SHELTON		4. DATE (Month) (Day) (Year) OF DEATH: June 29, 19 55	
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: March 17, 1889
9. AGE last birthday 66 yrs.		IF UNDER 1 YEAR Months 3 Days 12	IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired		10B. KIND OF BUSINESS OR INDUSTRY: Research Chemist	11. BIRTHPLACE (State or foreign country): Norristown, Tennessee
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME: John Thomas Shelton	
14. MOTHER'S MAIDEN NAME: Georgia Reed		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS: Mrs. Eve A. Shelton - Same Item #2	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) 420.0 Cardiac Decompensation			1 1/2 years
ANTECEDENT CAUSE (S) DUE TO Arrhythmia Fibrillation			1 1/2 yrs.
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO Arterio-sclerotic Heart Disease			5-10 yrs.
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: 0		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from July , 19 54 to June , 19 55 , that I last saw the deceased alive on June 23 , 19 55 , and that death occurred at 5 A M, from the causes and on the date stated above.			
SIGNATURE Frederic D. Chapman		ADDRESS M. D. 1834 Eye St. N. W. Wash. D. C. DATE SIGNED 6/29/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	DATE THEREOF 6/29/55	NAME OF CEMETERY OR CREMATORY Cedar Hill	LOCATION (City, town, or county) (State) Prince George Co. Maryland
DATE REC'D BY LOCAL REGISTRAR 6/30/55	REGISTRAR'S SIGNATURE Beacie M. Thompson	24. FUNERAL DIRECTOR Robert A. Humphrey	ADDRESS Bethesda, Maryland

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU W. B.

JUL 5 1955

RECEIVED

5798

CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY	Montg	STATE	Maryland
CITY (If outside corporate limits, write RURAL OR and give nearest town)	Gaithersburg	COUNTY	Montg
OR TOWN	Gaithersburg	CITY (If outside corporate limits, write RURAL and give nearest town)	Gaithersburg
HOSPITAL OR INSTITUTION OR STREET ADDRESS	23yrs	OR TOWN	Gaithersburg
		STREET ADDRESS (If rural give location)	8 Peony Drive
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First)	(Middle)	(Last)	(Month) (Day) (Year)
William	Stanley	Sheppard	June 3 1955
5. SEX:		6. AGE last birthday:	
Male	White	52 yrs.	8 Months 12 Days
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH:	
Married		Sept 21-1902	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY:	
Construction		Superintendent	
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
Cheva Chase, Md.		U S A	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
William Franklin Sheppard		Ella May Demory.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:	
(If Yes, give war or dates of service)		577-109 578	
17. INFORMANT & ADDRESS:		Anna P. Sheppard. Gaithersburg. Md.	

18. MEDICAL CERTIFICATION		Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		14 hours
Immediate cause (a) Coronary occlusion		
Antecedent causes (s) (b) arterio-sclerosis - several years		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c)		
11. OTHER SIGNIFICANT CONDITIONS		
Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY ?
		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR ?
22. I hereby certify that I attended the deceased from Jan 3, 1955, to June 3, 1955, that I last saw the deceased alive on June 3, 1955, and that death occurred at 9:30 PM, from the causes and on the date stated above.		
SIGNATURE (Degree or title)		DATE SIGNED
William C. Miller M.D. 7 Brookm. Gaithersburg, Md.		June 4-1955
23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY
Burial	6-6-55	Forest Oak
		LOCATION (City, town, or county) (State)
		Gaithersburg Md.
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS
June 4, 1955	Alfred G. Cooke	Ernest C. Gartner. Gaithersburg. Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

*General Register
Civil Service - Bureau*

BUREAU V. S.

JUN 7 1955

RECEIVED

Handwritten notes and signatures at the bottom of the page, including a date stamp "JUN 7 1955" and a signature.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 05801

5704

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		312 N. Boyle Ave., Los Angeles		STATE <u>Calif.</u> COUNTY <u>Los Angeles</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>17</u> <u>Takoma Park</u>		LENGTH OF STAY (in this place) <u>13 hrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Los Angeles</u> <u>43 X-3</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>75</u> <u>Washington San Hosp</u>				STREET ADDRESS (If rural give location) <u>312 N. Boyle Ave.</u> ✓			
3. NAME OF DECEASED: (Type or Print) (First) (Middle) (Last) <u>Janet Kathleen Smith</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>June 4</u> <u>1955</u>			
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>July 10, 1945</u>	9. AGE last birthday <u>9</u> yrs.	IF UNDER 1 YEAR: Months <u>10</u> Days <u>4</u>	IF UNDER 24 HRS.: Hours <u>4</u> Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY: <u>student</u>		11. BIRTHPLACE (State or foreign country): <u>Cranbrook, B.C. Canada</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Donald Alexander Smith</u>				14. MOTHER'S MAIDEN NAME: <u>Esther Ragnhild Lund</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.		17. INFORMANT & ADDRESS: <u>Father</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <u>752X</u>							
ANTECEDENT CAUSE (S):							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(A) <u>Increased Intracranial pressure</u>						<u>13 hrs.</u>	
(B) <u>Respiratory arrest</u>							
(C) <u>Hydrocephalus</u>						<u>9+ yrs.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Spina bifida</u>						<u>9+ yrs.</u>	
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 3, 1955</u> , to <u>June 4, 1955</u> , that I last saw the deceased alive on <u>June 4, 1955</u> , and that death occurred at <u>7:30 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>		ADDRESS <u>[Address]</u>		DATE SIGNED <u>6-4-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>June 6, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>George Washington Cemetery</u>		LOCATION (City, town, or county) (State) <u>Beaumont Rd. Hyattsville, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>June 4-1955</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>[Signature]</u>		ADDRESS <u>2844 CARROLL ST. N.W. Takoma Park 12, D.C.</u>	

RECEIVED

JUN 6 1955

BUREAU V. 8

MARYLAND

5705

05802

STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Takoma Park</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	
TOWN <u>3 hrs.</u>		TOWN <u>17</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington Sen + Hosp.</u>		STREET ADDRESS (If rural, give location) <u>7335 Flower Ave</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>HAROLD</u>	(Middle) <u>Eugene</u>	(Last) <u>SNIDE</u>
4. DATE OF DEATH	(Month) <u>6</u>	(Day) <u>22</u>	(Year) <u>1955</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>10-20-98</u>
9. AGE last birthday <u>58</u> yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Research Historian Library of Congress</u>	10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>58</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>New York</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	13. FATHER'S NAME <u>Fred Snide</u>	14. MOTHER'S MAIDEN NAME <u>Clara Lawrence</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	(If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS <u>Washington Sanatorium & Hosp. Records</u>

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
(a) <u>462.1 Ruptured esophagus, spontaneous & traumatic</u>		<u>6 hrs</u>
(b) <u>Esophageal cancer</u>		<u>yo</u>
(c) <u>There was no evidence of liver</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION <u>2</u>	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1949, to 6/22/1955, that I last saw the deceased alive on 6/22/1955, and that death occurred at 4:00 A.M. from the causes and on the date stated above.

SIGNATURE Dr. H. H. Holman, M.D. ADDRESS 500 W. Woodward St. N.W. DATE SIGNED 6/22/55

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>June 24, 1955</u>	NAME OF CEMETERY OR CREMATORY <u>Spring Washington Cemetery</u>	LOCATION (City, town, or county) <u>W. Des. Co</u>
DATE REC'D BY LOCAL REG. <u>JUNE 22-1955</u>	REGISTRAR'S SIGNATURE <u>J. Arthur Walters</u>	24. FUNERAL DIRECTOR <u>J. Arthur Walters</u>	ADDRESS <u>254 Carroll St NW</u>

10 C.

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JUN 24 1955

BUREAU V. S.

5714

05803

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Montg</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)		OR TOWN <u>Rockville R.F.D. #1</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>River Road</u>				STREET ADDRESS (If rural, give location)		<u>River Road</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Joseph Fulton Snouffer</u>				<u>June 3 1955</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>Mar. 18, 1900</u>	
9. AGE last birthday: <u>55</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Painter-Cont. Self-employ.</u>		11. BIRTHPLACE (State or foreign country): <u>Montg. Co. Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Benjamin Snouffer</u>				14. MOTHER'S MAIDEN NAME: <u>Adeliade Sheid</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY No.: <u>217-14-7298</u>		17. INFORMANT & ADDRESS: <u>R.F.D. #1</u>		<u>Wife-Emma Jane Snouffer-Rockville</u>	
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							<u>Found dead under auto</u>
911.0 Immediate cause (a) <u>Thoracic hemorrhage</u> DUE TO Antecedent cause(s) (b) <u>Crushed chest</u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>None</u>		21c. (City or town) (County) (State)		<u>Rockville R-1 Montg 15 md</u>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>6-3-55</u> ? P.M.		21e. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Crushed by car while attempted repair</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Frank J. Brosehart</u>		CHIEF MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER		DATE SIGNED <u>6-3-55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>6-3-55</u>		NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cem.</u>		LOCATION (City, town, or county) (State) <u>Rockville, Montg. Md.</u>	
DATE REC'D BY LOCAL REG. <u>6/7/55</u>		REGISTRAR'S SIGNATURE <u>Laurel H. Taylor</u>		M. FUNERAL DIRECTOR <u>Robert A. Campbell</u>		ADDRESS <u>Bethesda, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUN 8 1955

RECEIVED

5799

CERTIFICATE OF DEATH

Reg. Dist. No.

217

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u> CO		MARYLAND		STATE <u>MD</u> COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
OR TOWN <u>Rockville</u>		<u>Albany</u>		OR TOWN <u>Rockville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
				<u>Faithsburg 709</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>FRANCES GRIFFITH SPURRIER</u>				<u>June 2 1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Female</u>	<u>W</u>	<u>Married</u>	<u>Sept 24 1871</u>	<u>83</u> yrs.	Months	Days	Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>None</u>		<u>None</u>		<u>Montgomery</u>		<u>USA</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Frank Griffith</u>				<u>Catherine Riggs</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<u>No</u>				<u>None</u>		<u>Catherine Wilcox Faithsburg</u>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE				(A) <u>Uremia</u>			
ANTECEDENT CAUSE (S)				DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				(B) <u>Arterio-sclerosis, Nephritis.</u>			
				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
<u>None</u>				<u>None</u>			
20. AUTOPSY?				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
				<u>None</u>			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
<u>None</u>		<u>None</u>		<u>None</u>			
22. I hereby certify that I attended the deceased from <u>11/1</u> , 1948, to <u>6/2</u> , 1955, that I last saw the deceased alive on <u>5/31</u> , 1955, and that death occurred at <u>4 a</u> M, from the causes and on the date stated above.							
SIGNATURE <u>KMB:ib</u>				DATE SIGNED <u>6/2/55</u>			
M. D. <u>Sandy Spring Md</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>June 4 1955</u>		<u>Trinity Cemetery</u>		<u>Rockville Md</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>6-4-55</u>		<u>Arbuckle B. Taylor</u>		<u>Ray W. Barber</u>		<u>Rockville</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUN 10 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

05805

216

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>D.C.</u>	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Bethesda</u>	<u>5 days</u>	TOWN <u>Washington</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<u>74 Suburban</u>		<u>3244 38th St. N.W.</u> ✓	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <u>Celeste</u>	(Middle) <u>Genevieve</u>	(Last) <u>Starkloff</u>	(Month) <u>June</u> (Day) <u>30</u> (Year) <u>1955</u>
(Type or Print)			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
<u>Female</u>	<u>White</u>	<u>widow</u>	<u>Feb. 3, 1890</u>
9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>65</u> yrs.	Months	Days	Hours
			Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):
<u>Home</u>		<u>Housewife</u>	<u>Maryland</u>
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>Berry</u>			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		17. INFORMANT & ADDRESS:	
		<u>Hunter W. Starkloff</u> <u>5915 Crawford Drive, Rockville, Md.</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Bronchopneumonia</u>			<u>12 hrs</u>
ANTECEDENT CAUSE (S) <u>Cerebro-vascular accident</u>			<u>6 days</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			<u>unknown</u>
(B) <u>Hypertensive Cardiovascular disease</u>			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY?			
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>June 25, 1955</u> , to <u>June 30, 1955</u> , that I last saw the deceased alive on <u>June 30, 1955</u> , and that death occurred at <u>7:35 PM</u> , from the causes and on the date stated above.			
SIGNATURE		DATE SIGNED	
<u>Edouard Hunter, Jr.</u>		<u>6/30/55</u>	
M. D. <u>809 Kienhill Rd. Rockville</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>		<u>Perkinston Cemetery</u>	
DATE THEREOF		LOCATION (City, town, or county) (State)	
<u>7-3-55</u>		<u>Montgomery Co. Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		24. FUNERAL DIRECTOR	
<u>7/2/55</u>		<u>Beauregard M. Thornton</u>	
REGISTRAR'S SIGNATURE		ADDRESS	
		<u>The S. H. Hines Co. 2901 14th St. N.W. DC.</u>	

BUREAU V. S.

MAR 6 1955

RECEIVED

5706

CERTIFICATE OF DEATH

Reg. Dist. No. 223-

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
17 TOWN <u>Takoma Park</u>		14 days		TOWN <u>Silver Springs</u> 56			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
75 <u>Washington Sanitarium and Hospital</u>				<u>504 Bonifant St.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
<u>Rosa MINA Stein</u>				<u>6 1 1955</u>			
5. SEX:	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH:	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
<u>Female</u>	<u>White</u>	<u>married</u>	<u>7-8-81</u>	<u>73</u>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY:	
<u>Housewife</u>			<u>Own home</u>	<u>WASHINGTON, D.C.</u>		<u>U.S.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Charles Dietz</u>				<u>Olivia both Gobel</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS:			
			<u>none</u>	<u>Hospital Record</u>			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Uremia</u>						<u>12 months</u>	
ANTECEDENT CAUSE (S): (B) <u>Nephrosclerosis</u>						<u>at least 5 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Arteriosclerosis and hypertension</u>						<u>at least 5 years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug 23, 1939</u> , to <u>June 1, 1955</u> , that I last saw the deceased alive on <u>May 31, 1955</u> , and that death occurred at <u>8:30 a.m.</u> from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
<u>Aaron H. Trau</u>		<u>M. D. 8237 Georgia Ave. Silver Spring Md.</u>		<u>June 1 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>6/4/55</u>		<u>Prospect Hill Cemetery</u>		<u>Washington, D. C.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTER'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>June 3-1955</u>		<u>F. Wilson Doherty</u>		<u>Warner L. Humphrey</u>		<u>8434 Ga. Ave. Silver Spring, Md.</u>	

MARGIN RESERVED FOR BINDING

RECEIVED
JUN 9 1955
BUREAU V. S.

9 1955 JUN

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05807

5801

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u> MARYLAND				STATE <u>District of Columbia</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>TOWN Bethesda Rural</u>				CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>TOWN Washington, D.C.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Naval Hospital</u>				STREET ADDRESS (If rural give location) <u>1336 Missouri Avenue, N.W.</u>			
3. NAME OF DECEASED:		(First) (Middle) (Last)		4. DATE (Month) (Day) (Year)		OF DEATH:	
(Type or Print)		<u>Albert (N) SUSSMAN</u>		<u>June 23</u>		<u>19 55</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>1-6-98</u>	<u>57 yrs.</u>	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Salesman</u>			10B. KIND OF BUSINESS OR INDUSTRY: <u>Real Estate</u>		11. BIRTHPLACE (State or foreign country): <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME: <u>Isac SUSSMAN</u>				14. MOTHER'S MAIDEN NAME: <u>Tuba BRUDSKY</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>yes WW I</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT & ADDRESS: <u>Wife Frances SUSSMAN Same as above</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Massive Gastro-intestinal hemorrhage</u>						<u>24 hrs</u>	
ANTECEDENT CAUSE (S) <u>Acute and chronic duodenal ulceration</u>						<u>25 yrs.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(B) <u>Bronchogenic carcinoma c metastases</u>						<u>6 months</u>	
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11 May</u> , 19 <u>55</u> to <u>23 June</u> , 19 <u>55</u> that I last saw the deceased alive on <u>23 June</u> , 19 <u>55</u> , and that death occurred at <u>10:00A</u> M, from the causes and on the date stated above.							
SIGNATURE <u>H. I. Passes Lt MC USN</u>				ADDRESS <u>P. NMMC, Bethesda, Maryland</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>6-24-55</u>		<u>Arlington National</u>		<u>Arlington, Virginia</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>23 June 1955</u>		<u>Mary E. Farrell</u>		<u>Danzansky Funeral Home</u>		<u>2901 17th Street, N.W., Washington, D.C.</u>	

BUREAU V. S.

JUN 27 1955

RECEIVED

05808

MARYLAND 5892

STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 214

Item 11. Film G123 7-55 et.

Items 13, 14 Film G185 8-12-55 et

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Montgomery</u> COUNTY <u>St. Georges</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>16-34-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Lebanon Gardens</u>		STREET ADDRESS (If rural, give location) <u>4300-40th St.</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Joseph H. Sweeney</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>June 10- 1955</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>85 yrs.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gasfitter</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Wheeling, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Thomas Sweeney</u>		14. MOTHER'S MAIDEN NAME <u>Mary Maher</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		17. INFORMANT AND ADDRESS <u>Miss Margaret Sweeney, Daughters</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

422.1

Immediate cause

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(a) Chronic Myocarditis
Sen. Arteriosclerosis
Senility

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Jan. 1, 1955, to June 10, 1955, that I last saw the deceased alive on June 18, 1955 and that death occurred at 5:45 a.m., from the causes and on the date stated above.

SIGNATURE <u>Richard B. Thibadeau M.D.</u>		ADDRESS <u>Columbia Road, Sil Sp. Md.</u>		DATE SIGNED <u>6/20/55</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Removal</u>		DATE <u>6/20/55</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Rainier M.D.</u>	
DATE REC'D BY LOCAL REG <u>6-22-55</u>		REGISTRAR'S SIGNATURE <u>Frances Potter</u>		24. FUNERAL DIRECTOR <u>Wally's Funeral Home</u>	
				ADDRESS <u>2200- R. I. ave. Mt. Rainier Md.</u>	

MARGIN RESERVED FOR BINDING

BUREAU V. 8

JUN 24 1955

RECEIVED

RECEIVED

5893

CERTIFICATE OF DEATH

Reg. Dist. No. 215.....

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>District of Columbia</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		47X 3	
X TOWN <u>Bethesda Rural</u>		50 days		Washington, D.C.			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Naval Hospital</u>				STREET ADDRESS (If rural give location) <u>817 L Street, N.W.</u>			
3. NAME OF DECEASED: (First) <u>Andrew</u>		(Middle) <u>(N)</u>		(Last) <u>TAYLOR</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>June 29 19 55</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>5-3-88</u>	9. AGE last birthday <u>67</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Shipping clerk</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>GPO</u>		11. BIRTHPLACE (State or foreign country): <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Robert TAYLOR</u>				14. MOTHER'S MAIDEN NAME: <u>Julia CHINN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes WW I</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT & ADDRESS: <u>Wife Mrs. Emma Taylor Same as above</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
177X IMMEDIATE CAUSE		(A) <u>Renal failure & acidosis</u>				<u>7 days</u>	
ANTECEDENT CAUSE (S)		DUE TO					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(B) <u>CRACINOMA PROSTATE & Extensive metastatic disease</u>				<u>unknown</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>1 June 1955</u>		19B. MAJOR FINDINGS OF OPERATION: <u>CRACINOMA, Prostate</u>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9 May</u> , 19 <u>55</u> to <u>29 June</u> , 19 <u>55</u> that I last saw the deceased alive on <u>29 June</u> , 1955, and that death occurred at <u>2:05 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>W. E. Fraser</u>				ADDRESS		DATE SIGNED	
W. E. FRASER LCDR MC USN U. S. Naval Hospital, NNMC Bethesda Md.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>7-5-55</u>		NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
DATE REC'D BY LOCAL REGISTRAR <u>6-30-55</u>		REGISTRAR'S SIGNATURE <u>Mary E. Russell</u>		24. FUNERAL DIRECTOR <u>Chinn Funeral Home</u>		ADDRESS <u>2605 S. Semny Road, Washington, D.C.</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUL 1 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5715

05810

Reg. Dist. No. 24

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

I. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>DC</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Rockville</u>		LENGTH OF STAY (in this place) <u>4 days</u>		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Washington</u>		<u>47X-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>11813 Old Drovers way Randolph Hills</u>				STREET ADDRESS (If rural, give location) <u>5000 Bates Rd N.E.</u>			
3. NAME OF DECEASED: (First) <u>Flora</u> (Middle) <u>Belle</u> (Last) <u>Taylor</u>				4. DATE OF DEATH (Month) <u>June</u> (Day) <u>18</u> (Year) <u>1955</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widow</u>		8. DATE OF BIRTH: <u>2-18-1882</u>	
9. AGE last birthday: <u>73</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Canada</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				13. FATHER'S NAME: <u>Norman MacLeod</u>			
14. MOTHER'S MAIDEN NAME: <u>Ann Mathews</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			
16. SOCIAL SECURITY No.:				17. INFORMANT & ADDRESS: <u>Vertude Wright (daughter)</u> <u>Same as item 1</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
420.1 Immediate cause (a) <u>Coronary occlusion</u> DUE TO Antecedent cause(s) (b) <u>hypertension</u> Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u>2 yrs</u>						<u>sudden</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Fracture left hip 5/15/55</u>							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, street, office bldg., etc., INJURY)		21c. (City or town) (County)		(State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>. SIGNATURE <u>Frank J. Brochart</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>6-18-55</u> M. D. <u>DEPUTY MEDICAL EXAMINER</u> <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>							
23. BURIAL, CREMATION, REMOVAL (Specify): <u>BURIAL</u>		DATE THEREOF <u>6-17-1955</u>		NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEMETERY</u>		LOCATION (City, town, or county) (State) <u>PRINCE GEORGE'S CO. MD.</u>	
DATE REC'D BY LOCAL REG. <u>6-22-55</u>		REGISTRAR'S SIGNATURE <u>James Miller</u>		24. FUNERAL DIRECTOR <u>L.H. Hines Co., Washington 9, D.C.</u>		ADDRESS	

JUN 24 1955

BUREAU V. S.

584

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>District of Columbia</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>TOWN Bethesda Rural</u>		LENGTH OF STAY (in this place) <u>78 Days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>TOWN Washington, D.C.</u>		<u>47X-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Naval Hospital</u>				STREET ADDRESS (If rural give location) <u>1819 K Street, N.W.</u>			
3. NAME OF DECEASED: (First) <u>Paul</u>		(Middle) <u>(N)</u>		(Last) <u>TAYLOR</u>		4. DATE OF DEATH: (Month) <u>June</u> (Day) <u>26</u> (Year) <u>19 55</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>5-16-74</u>	9. AGE last birthday <u>81 yrs.</u>	IF UNDER 1 YEAR: Months _____ Days _____	IF UNDER 24 HRS.: Hours _____ Min. _____	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Government Clerk</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Government</u>		11. BIRTHPLACE (State or foreign country): <u>Texas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Elisha TAYLOR</u>				14. MOTHER'S MAIDEN NAME: <u>Frances TILLEY</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u>		16. SOCIAL SECURITY NO. (If Yes, give war or dates of service) <u>Spanish American Unknown</u>		17. INFORMANT & ADDRESS: <u>Wife Mrs. Dolly W. TAYLOR</u> <u>Same as above</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Ca. 9 months 2 metastases</u>						<u>1 year.</u>	
ANTECEDENT CAUSE (S)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>Cerebrovascular obstruction due to arteriosclerosis - M.C.</u>							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>A.S.H.D.</u>						<u>yes.</u>	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>19 March, 1955</u> , to <u>26 June, 1955</u> , that I last saw the deceased alive on <u>26 June, 1955</u> , and that death occurred at <u>3:30 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>A. J. Caporale</u>				ADDRESS		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>6-28-55</u>		NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
DATE REC'D BY LOCAL REGISTRAR <u>6-28-55</u>		REGISTRAR'S SIGNATURE <u>Mary E. Carrelly</u>		24. FUNERAL DIRECTOR <u>Cawlers Funeral Home</u>		ADDRESS <u>1756 Pennsylvania Ave., N.W., Wash., D.C.</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUN 28 1955

RECEIVED

5805

MARYLAND STATE DEPARTMENT OF HEALTH

05812

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
TOWN <u>Silver Spring</u>		TOWN <u>Silver Spring</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>10209 Douglas Ave</u>		STREET ADDRESS (If rural, give location) <u>10209 Douglas Ave.</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>James Norris Thompson</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>June 28 1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>July 28 1888</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plate Printer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gov't.</u>	9. AGE last birthday <u>66</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Chester, Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Thompson</u>		14. MOTHER'S MAIDEN NAME <u>Harriette</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Fred Thompson, Silver Spring, Md.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Cerebral hemorrhage</u>		<u>3 mo.</u>
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION <u>None</u>	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>None</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>None</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Mar, 1952, to June 28, 1955, that I last saw the deceased alive on June 27, 1955, and that death occurred at 3:45 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
John Lawrence Avery M.D. 10110 Georgia Ave. Silver Spring Md 6/28/55
 23. BURIAL CREMATION REMOVAL (Specify) DATE THEREOF NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county) (State)
7-1-55 Cedar Hill Spittlane Md.
 DATE REC'D BY LOCAL REG. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR ADDRESS
6-28-55 Frances Potter Timothy Newlon 3831-G St. Ave. N.W.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1953
67
1886

RECEIVED

JUN 30 1955

BUREAU V. 2

5806

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u> MARYLAND				STATE <u>Paris, France</u> COUNTY			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Bethesda Rural</u>				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Paris</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Naval Hospital</u>				STREET ADDRESS (If rural give location) <u>129 Rue D La Tour</u>			
3. NAME OF DECEASED: (First) <u>Charles</u> (Middle) <u>Eldred</u> (Last) <u>TUCKER III</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>June 25 1955</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>		8. DATE OF BIRTH: <u>3-27-49</u>	
9. AGE last birthday <u>6 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		11. BIRTHPLACE (State or foreign country): <u>Texas</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME: <u>Charles E. TUCKER Jr.</u>				14. MOTHER'S MAIDEN NAME: <u>Jane ALLAN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT & ADDRESS: <u>Father Charles E. TUCKER Jr. Same as above</u>							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Pyogenic meningitis</u>						<u>2 months.</u>	
ANTECEDENT CAUSE (B) <u>CSF Rhinorrhea</u>						<u>3 months.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Severe craniocerebral injury</u>						<u>3 months.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Hydrocephalus, internal</u>							
19A. DATE OF OPERATION: <u>3-23-55</u>		19B. MAJOR FINDINGS OF OPERATION: <u>Biateral frontal lobe distention, CSF leak</u>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.) <u>Street</u>		21C. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>Paris, France</u>			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: <u>March 5 1955 M.</u>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>Struck by truck</u>			
22. I hereby certify that I attended the deceased from <u>18 March, 1955</u> to <u>25 June 1955</u> , that I last saw the deceased alive on <u>25 June 1955</u> , and that death occurred at <u>11:23 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>C. C. MUEHE</u>				ADDRESS <u>U. S. Naval Hospital, DNNMC, Bethesda, Maryland</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>6-29-55</u>		NAME OF CEMETERY OR CREMATORY <u>Private Cemetery</u>		LOCATION (City, town, or county) (State) <u>Duval County, Florida</u>	
DATE REC'D BY LOCAL REGISTRAR <u>6-26-55</u>		REGISTRAR'S SIGNATURE <u>Ray E. Farrell</u>		24. FUNERAL DIRECTOR ADDRESS <u>R. A. Pumphrey Funeral Home 7557 Wisconsin Avenue, Bethesda, Md.</u>			

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians' please write the causes of death clearly and legibly.

RECEIVED

JUN 28 1955

BUREAU V. S.

Handwritten notes, including "Specimens mounted", "CST Rhinoceros", "Some cranial injury", "Heterophages", "Heterophages for collection", "CST Rhinoceros", "Specimens mounted", "CST Rhinoceros", "Some cranial injury", "Heterophages", "Heterophages for collection", "CST Rhinoceros".

3 months
3 months
3 months

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05814

5707

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Montgomery	MARYLAND	STATE Md.	COUNTY Prince George
CITY (If outside corporate limits, write RURAL and give nearest town) 17 Takoma Park	LENGTH OF STAY (in this place) 4 days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN W. Hyattsville	15-2
HOSPITAL OR INSTITUTION OR STREET ADDRESS 75 Washington Sanitarium Hospital		STREET ADDRESS (If rural give location) 1929 Laguna Road	✓
3. NAME OF DECEASED: (Type or Print)		4. DATE (Month) (Day) (Year)	
Lena (First) Mary (Middle) Van Horn (Last)		6 - 7 - 1955	
5. SEX: Fe	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED: married	8. DATE OF BIRTH: 8-10-93
9. AGE last birthday 61 yrs.		10. BIRTHPLACE (State or foreign country): Maryland	
11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Louis Phillips		14. MOTHER'S MAIDEN NAME: Regina Frey or Frye	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO. 577-07-6028	
17. INFORMANT'S ADDRESS: Hospital Record			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE 170X Metastatic Carcinoma			
ANTECEDENT CAUSE (S): Carcinoma of Breast			2 years
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from March, 1954 , to June 7, 1955 , that I last saw the deceased alive on June 7, 1955 , and that death occurred at 4:05 P M, from the causes and on the date stated above.			
SIGNATURE Boris Roblin M.D.		DATE SIGNED June 7, 1955	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		24. FUNERAL DIRECTOR	
DATE REC'D BY LOCAL REGISTRAR June 9 1955		ADDRESS 8434 Ga. Ave. Silver Spring, Md.	
REGISTRAR'S SIGNATURE J. Milton Doehl		ADDRESS Warner E. Humphrey	

BUREAU V. 2

JUN 13 1955

RECEIVED

Trans 13, 14 Film 183 6-27-55 et

5897

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>District of Columbia</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Bethesda Rural</u>		<u>34 days</u>		TOWN <u>Washington, D.C.</u>		<u>16X2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Naval Hospital</u>				STREET ADDRESS (If rural give location) <u>2715 79th Avenue, S.E.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
DECEASED: (Type or Print) <u>Carl Maria Johaan VON ZIELINSKI</u>				DEATH: <u>June 16 19 55</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>7-22-85</u>	<u>69 yrs.</u>	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Int. Law</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>International Law</u>		11. BIRTHPLACE (State or foreign country): <u>Poland</u>	
13. FATHER'S NAME: <u>Unknown Carl Gregor von Zielinski</u>				14. MOTHER'S MAIDEN NAME: <u>Unknown Marie von Beringe</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.): <u>Yes</u> (If Yes, give war or dates of service) <u>WW I WWII</u>				16. SOCIAL SECURITY NO. <u>577-48-1877</u>		17. INFORMANT & ADDRESS: <u>Wife Isobel G. VON ZIELINSKI Same as above</u>	
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Pulmonary edema</u>							<u>6 hours</u>
ANTECEDENT CAUSE (S) DUE TO (B) <u>Arterio-sclerotic heart disease</u>							<u>unknown</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>2</u>				19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		21F. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from <u>13 May, 1955</u> , to <u>16 June, 19 55</u> that I last saw the deceased alive on <u>16 June, 1955</u> , and that death occurred at <u>6:05PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>I. M. Taylor</u>				ADDRESS		DATE SIGNED	
I. M. TAYLOR LCDR MC USNAU. S. Naval Hospital, NNMC, Bethesda, Maryland							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>20 June 1955</u>		<u>Arlington National</u>		<u>Arlington, Virginia</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>6-17-55</u>		<u>Mary E. Carvelly</u>		<u>R. A. Pumphrey Funeral Home</u>		<u>7557 Wisconsin ave. Bethesda, Maryland</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 20 1955

BUREAU V. E.

5898

05816

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 212

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY	Montgomery	MARYLAND	STATE	Maryland	COUNTY Carroll
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN		
X TOWN Olney		1 day	Mt. Airy 06X-2		
HOSPITAL OR INSTITUTION OR STREET ADDRESS			STREET ADDRESS (If rural, give location)		
The Montgomery County General Hospital, Inc.					
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE OF DEATH (Month) (Day) (Year)			
(Type or Print) John Wesley Waters		June 27 19 55			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR IF UNDER 24 HRS.
male	colored	single	10/26/00	54 yrs.	Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?
laborer		construction	Virginia		U S.A.
13. FATHER'S NAME:			14. MOTHER'S MAIDEN NAME:		
Will Waters			Drucilla Fountain		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:	17. INFORMANT & ADDRESS:		
(If Yes, give war or dates of service)			Hospital Records		

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:				
445X Immediate cause (a).....				
Passive congestion of lungs DUE TO				
Antecedent cause(s) (b).....				
Diseases or conditions, if any, giving rise to the above cause DUE TO				
stating underlying cause last (c).....				
Malignant hypertension				2 days
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .				
SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED		
Frank J. Bruschart		DEPUTY MEDICAL EXAMINER <input type="checkbox"/> 6-28-55		
M. D.		ASSISTANT MEDICAL EXAM.		
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial		7-2-55	Danmaeus	Danmaeus, Md.
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS
7-2-55		Bertrude B. Lawler		Robert L. Sworley, Rockville, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUL 8 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5809

05817

Reg. Dist. No. 218

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
<input checked="" type="checkbox"/> TOWN <u>Gaithersburg</u>				<input checked="" type="checkbox"/> TOWN <u>Gaithersburg</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS		<u>23 DeSillum Ave</u>		STREET ADDRESS (If rural, give location)			
				<u>10 George St.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Louis Fillmore Watkins</u>				<u>June 3 19 55</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>Dec. 5, 1879</u>	<u>75</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Retired Foreman State Road</u>				<u>Montgomery Co. Md.</u>		<u>USA</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>C. Fillmore Watkins</u>				<u>Louise Elizabeth Lydard</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
<u>No</u>		<u>217-32-3483</u>		<u>Mrs Katie L. Watkins, Gaithersburg, Md.</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
<u>420.1</u> Immediate cause (a) <u>Coronary occlusion</u> DUE TO							<u>Sudden</u>
Antecedent cause(s) (b) <u></u> Diseases or conditions, if any, giving rise to the above cause DUE TO							<u>diarr</u>
stating underlying cause last (c) <u></u>							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:			19b. MAJOR FINDING OF OPERATION:			20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.							
SIGNATURE <u>Frank J. Broschant</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>6-4-55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>June 6, 1955</u>		<u>Mt. Lebanon</u>		<u>Nr. Damascus, Md.</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>June 5-55</u>		<u>Abundant G. Cook</u>		<u>Olin L. Molesworth, Damascus, Md.</u>			

RECEIVED

JUN 7 1955

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5810

CERTIFICATE OF DEATH

Reg. Dist. No. 216

05818

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write and give nearest town) <u>Bethesda</u>		RURAL LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write and give nearest town) <u>Silver Spring Md</u>		OR TOWN <u>56</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital</u>				STREET ADDRESS (If rural give location) <u>12218 Kendall Street</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
<u>Martin W. Weld</u>				<u>June 25 1955</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>5/30/91</u>	9. AGE last birthday <u>64</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
				Months	Days	Hours	Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Circulation mgr.</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>Maryland News</u>		11. BIRTHPLACE (State or foreign country): <u>Pennsylvania</u>	
13. FATHER'S NAME: <u>John Weld</u>				14. MOTHER'S MAIDEN NAME: <u>Jane Schopf</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Elna B. Weld, wife - same address</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Septicemia</u>						<u>days</u>	
ANTECEDENT CAUSE (S) DUE TO (B) <u>Pylonephritis, Chronic</u>						<u> yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Pericarditis</u>						<u>months</u>	
19A. DATE OF OPERATION: <u>2</u>				19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>June 1</u> , 19 <u>55</u> , to <u>June 25</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>June 1</u> , 19 <u>55</u> , and that death occurred at <u>9:30</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Belden R. Reap M.D.</u>				ADDRESS <u>Silver Spring, Md.</u>		DATE SIGNED <u>6/25/55</u>	
23. BURIAL, CREMATION, REMAINS (Specify)		DATE THEREOF <u>6-28-55</u>		NAME OF CEMETERY OR CREMATORY <u>Corktown</u>		LOCATION (City, town or county) (State) <u>Rockville Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>6/27/55</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		24. FUNERAL DIRECTOR <u>W. W. Chambers</u>		ADDRESS <u>1400 Chapin</u>	

BUREAU V. S.

JUN 30 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

5811

05819

1. PLACE OF DEATH COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Montgomery	
CITY (If outside corporate limits, write RURAL and give nearest town) Washington 16 OR Washington 16 TOWN American University Park		CITY (If outside corporate limits, write RURAL and give nearest town) Washington 16 OR Washington 16 TOWN American University Park	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 4831 Park Ave		STREET ADDRESS (If rural, give location) 4831 Park Ave.	
3. NAME OF DECEASED (Type or Print)	(First) Daniel	(Middle) Perzon	(Last) Wells
6. SEX Male	7. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	4. DATE OF DEATH June 5 1953
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Post Office Clerk	10b. KIND OF BUSINESS OR INDUSTRY US Govt.	8. DATE OF BIRTH 9-1-1883	9. AGE last birthday 71 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
13. FATHER'S NAME George T. Wells	14. MOTHER'S MAIDEN NAME Elizabeth Sullivan		12. CITIZEN OF WHAT COUNTRY? US
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. None	17. INFORMANT AND ADDRESS Elizabeth Wells-Item # 2	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) Myocardial Infarction			4 min
Antecedent cause(s) (b) Coronary Arteriosclerotic Heart Disease			10 yrs
(c) Multiple Cerebral Thromboses			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 1945 , to June 5, 1953 , that I last saw the deceased alive on May 25, 1953 , and that death occurred at 4:20 a.m. , from the causes and on the date stated above.			
SIGNATURE Thos. G. Velicer MD.		ADDRESS 1150 Conn. Ave NW Wash. DC.	DATE SIGNED 6/5/53
23. BURIAL CREMATION REMOVAL (Specify) Burial	DATE THEREOF 6-8-55	NAME OF CEMETERY OR CREMATORY Mt. Olivet	LOCATION (City, town, or county) (State) Washington, D.C.
DATE REC'D BY LOCAL REG. 6/7/55	REGISTRAR'S SIGNATURE Bessie M. Thompson	24. FUNERAL DIRECTOR Robert A. Rindgey	ADDRESS Bethesda, Md.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUN 9 1955

RECEIVED

5812

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u> MARYLAND				STATE <u>md</u> COUNTY <u>montgomery</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Bethesda</u>				CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> 26			
TOWN <u>Bethesda</u> 1 hour				TOWN <u>Rockville</u> 26			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban</u>				STREET ADDRESS (If rural give location) <u>13116 Okinawa ave.</u>			
3. NAME OF DECEASED: (Type or Print) <u>Baby Girl West</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>JUNE 3 1955</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>		8. DATE OF BIRTH: <u>June 3/55</u>	
9. AGE last birthday: <u>0</u> yrs.		10. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u>		11. IF UNDER 24 HRS.: Hours <u>1</u> Min. <u>8</u>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Infant</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>—</u>		11. BIRTHPLACE (State or foreign country): <u>USA (md)</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME: <u>Arthur James West</u>				14. MOTHER'S MAIDEN NAME: <u>Esther Loretta Eddy</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>no</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.: <u>None</u>		17. INFORMANT & ADDRESS: <u>Mother (same)</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
762.5 IMMEDIATE CAUSE (A) <u>Anoxia</u>		1 hour 8 min
ANTECEDENT CAUSE (S) DUE TO (B) <u>Inadequate pulmonary development</u>		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Prematurity (6 mos gestation)</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8:12 PM, 1955, to 9:30 PM, 1955, that I last saw the deceased alive on June 3, 1955, and that death occurred at 9:30 PM, from the causes and on the date stated above.

SIGNATURE <u>J. Marshall Curillier</u>	DATE SIGNED <u>June 3, 1955</u>
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>6/6/1955</u>
NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>	LOCATION (City, town, or county) (State) <u>Rockville Maryland</u>

DATE REC'D BY LOCAL REGISTRAR <u>6/7/55</u>	REGISTRAR'S SIGNATURE <u>Bessie S. Thompson</u>	24. FUNERAL DIRECTOR <u>Robert A. Humphrey</u>	ADDRESS <u>Bethesda, Md.</u>
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MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUN 9 1935

RECEIVED

5813

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Virginia</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
X TOWN <u>Bethesda</u>		<u>63 days</u>		TOWN <u>Alexandria</u> <u>83X-3</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>The Clinical Center</u>				STREET ADDRESS (If rural give location)			
50 <u>Natl. Institutes of Health</u>				<u>1449 Martha Custis Drive</u> ✓			
3. NAME OF DECEASED:		(First) (Middle) (Last)		4. DATE (Month) (Day) (Year)			
(Type or Print) <u>Lucille</u>		<u>Spencer</u> <u>Wien</u>		DATE OF DEATH: <u>June 2</u> <u>1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>F</u>	<u>W</u>	<u>Married</u>	<u>January 21, 1892</u>	<u>63 yrs.</u>	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life. even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Clerk</u>		<u>Not stated</u>		<u>North Carolina</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>C. Mann</u>				<u>Ella Dill</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
<u>No</u> (If Yes, give war or dates of service)		<u>Not available</u>		<u>The medical record, The Clinical Center</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Intestinal hemorrhage</u>							
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>Leukemia</u>							
(C) <u>Diabetes mellitus</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Arteriosclerotic heart disease</u>							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
---		---					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		---	
---		M.		---			
22. I hereby certify that I attended the deceased from <u>Mar. 31, 1955</u> , to <u>June 2, 1955</u> , that I last saw the deceased alive on <u>June 2, 1955</u> , and that death occurred at <u>2 A.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>J. Leonard Hol</u>				DATE SIGNED <u>2 June 1955</u>			
The Clinical Center				M.D. <u>Natl. Institutes of Health</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>6-3-55</u>		<u>Fort Lincoln</u>		<u>Washington D.C.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>6/4/55</u>		<u>Beattie M. Thompson</u>		<u>Wesley Funeral Home</u>		<u>227 E. G. Sutphin</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUN 7 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05822

5716

CERTIFICATE OF DEATH

Reg. Dist. No. 213

Item 6, Film 6183 7-11-55 et

1. PLACE OF DEATH: <i>Montgomery</i>				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>17 Williams St. Rockville</i>		STATE <i>Maryland</i> COUNTY <i>Montgomery</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Rockville</i>		26	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Rockville Md.</i>		LENGTH OF STAY (in this place) <i>18 yrs.</i>		STREET ADDRESS (If rural give location) <i>19 Williams St.</i>		26	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>19 Williams St.</i>				08			
3. NAME OF DECEASED: (First) (Middle) (Last) <i>Emily Fager Williams</i>				4. DATE OF DEATH: (Month) (Day) (Year) <i>6 30 1955</i>			
5. SEX: <i>Female</i>		6. COLOR OR RACE: <i>White</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Widowed</i>		8. DATE OF BIRTH: <i>June 3 1894</i>	
9. AGE last birthday <i>61</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY: <i>None</i>		11. BIRTHPLACE (State or foreign country): <i>Eastern Md.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME: <i>Robert B. Fager</i>		14. MOTHER'S MAIDEN NAME: <i>Mary Laidley Simpson</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <i>No.</i>	
16. SOCIAL SECURITY NO. <i>220-28-6609</i>		17. INFORMANT & ADDRESS: <i>19 Williams St.</i>		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				410X IMMEDIATE CAUSE		3 W	
ANTECEDENT CAUSE (S)				(A) DUE TO <i>embol thrombosis</i>		40 Y	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				(B) DUE TO <i>mitral stenosis</i>		40 Y	
				(C) <i>Rheumatic Fever</i>		40 Y	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>1936</i> to <i>6/30 55</i> , that I last saw the deceased alive on <i>6/30/55</i> , 19 <i>55</i> , and that death occurred at <i>11:40 P.M.</i> , from the causes and on the date stated above.							
SIGNATURE <i>W. Webb R.D.</i>				ADDRESS <i>Rockville</i>		DATE SIGNED <i>7/2/55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>July 2, 1955</i>		NAME OF CEMETERY OR CREMATORY <i>Rockville Union</i>		LOCATION (City, town, or county) (State) <i>Rockville, Montgomery Co. Md.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>7/5/55</i>		REGISTRAR'S SIGNATURE <i>Laurel H. Kragtorp</i>		24. FUNERAL DIRECTOR <i>R.H. Humphrey</i>		ADDRESS <i>7557 Wis. Ave. Bk. Md.</i>	

BUREAU V. S.

JUL 6 1955

RECEIVED

5814

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Montgomery	MARYLAND	STATE Virginia	COUNTY Princess Ann
CITY (If outside corporate limits, write RURAL and give nearest town) Bethesda	LENGTH OF STAY (in this place) 48 days	CITY (If outside corporate limits, write RURAL and give nearest town) Oceana	
HOSPITAL OR INSTITUTION OR STREET ADDRESS The Clinical Center Nat'l Institutes of Health	STREET ADDRESS (If rural give location) -- Box 48		
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year) OF DEATH:	
(First) Thelma	(Middle) Elizabeth	(Last) Wilson	June 21 1955
5. SEX: F	6. COLOR OR RACE: Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: 27 Aug. 1915
9. AGE last birthday 39 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife		10B. KIND OF BUSINESS OR INDUSTRY: none	11. BIRTHPLACE (State or foreign country): North Carolina
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME: Columbus Gay	
14. MOTHER'S MAIDEN NAME: Caroline Perkins		15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service) No --	
16. SOCIAL SECURITY NO. 225-12-4127		17. INFORMANT & ADDRESS: The Medical Record, The Clinical Center	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) Metastatic carcinoma of the cervix uteri			
ANTECEDENT CAUSE (B) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: --		19B. MAJOR FINDINGS OF OPERATION: --	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) --	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? --			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY -- M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
21F. HOW DID INJURY OCCUR? --			
22. I hereby certify that I attended the deceased from 4 May, 1955 , to June 21, 1955 , that I last saw the deceased alive on June 21, 1955 , and that death occurred at 8:00AM , from the causes and on the date stated above.			
SIGNATURE Pittman		DATE SIGNED 6/22/55	
23. BURIAL, CREMATION, REMOVAL (Specify): Removal		DATE THEREOF 6-23-55	
NAME OF CEMETERY OR CREMATORY --		LOCATION (City, town, or county) (State) Norfolk, Va.	
DATE REC'D BY LOCAL REGISTRAR 6/22/55		REGISTRAR'S SIGNATURE Bessie M. Thompson	
24. FUNERAL DIRECTOR Frazier		ADDRESS Fun. Home 389-R-Clare	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUN 27 1955

RECEIVED

5798
CERTIFICATE OF DEATH

Reg. Dist. No. 223-

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Penn.</u>		COUNTY <u>Allegheny</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Gibsonia</u> <u>75 X-3</u>			
TOWN <u>Takoma Park</u>		<u>10 days</u>		STREET ADDRESS (If rural give location) <u>Box 63 C - Ewalt rd.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Wash. San. & hosp.</u>							
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH: <u>June 30 1955</u>			
<u>Marjorie Laura Wolf</u>							
5. SEX: <u>Fe</u>	6. COLOR OR RACE: <u>Cauc.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married</u>	8. DATE OF BIRTH: <u>3-22-99</u>	9. AGE last birthday: <u>56</u> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>House wife</u>				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Penn.</u>	
13. FATHER'S NAME: <u>John Shields</u>				14. MOTHER'S MAIDEN NAME: <u>Laura</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>No</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS:	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Generalized Carcinomatosis</u>						<u>4 mos.</u>	
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B)							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>March 1955</u>				19B. MAJOR FINDINGS OF OPERATION: <u>Carcinoma of Ovary ± metastases</u>			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Dry) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 26 1955</u> , to <u>June 30 1955</u> that I last saw the deceased alive on <u>June 30 1955</u> , and that death occurred at <u>7:00 P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Rene Williamson</u>		ADDRESS <u>M. D. 8700 Coleville Rd Silver Spring, Md 9415</u>		DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY): <u>Burial - Trans.</u>		DATE THEREOF: <u>July 5, 1955</u>		NAME OF CEMETERY OR CREMATORY: <u>Hampton Cem.</u>		LOCATION (City, town, or county) (State): <u>Gibsonia, Allegheny Co. Pa.</u>	
DATE REC'D BY LOCAL REGISTRAR: <u>June 30 1955</u>		REGISTRAR'S SIGNATURE: <u>J. Wilson</u>		24. FUNERAL DIRECTOR: <u>254 Capitol St NW</u>		ADDRESS: <u>Takoma Park, D.C.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

STATEMENT OF DEATH

JUL 5 1955

BUREAU V. 41

RECEIVED

5709

CERTIFICATE OF DEATH

Reg. Dist. No. 223...

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Montgomery</i>		MARYLAND		STATE <i>Maryland</i> COUNTY <i>Montgomery</i>			
CITY (If outside corporate limits, write RURAL and give nearest town) <i>17 Gethsemane Park</i>		LENGTH OF STAY (in this place) <i>13 years</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>17 Gethsemane Park</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>1304 ELSON PLACE</i>				STREET ADDRESS (If rural give location) <i>1304 Elson place</i>			
3. NAME OF DECEASED: (Type or Print) (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<i>ANNA C WOODRUFF</i>				<i>6 20 1955</i>			
5. SEX: <i>F</i>	6. COLOR OR RACE: <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Widowed</i>	8. DATE OF BIRTH: <i>5-17-1862</i>	9. AGE last birthday <i>93</i> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>housewife</i>			10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <i>Sweden</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME: <i>John Swanson</i>				14. MOTHER'S MAIDEN NAME: <i>Unknown</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT & ADDRESS: <i>Mrs. William T. Pierce</i>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <i>Cardiac Failure</i>						<i>7 days</i>	
ANTECEDENT CAUSE (S) (B) <i>Cardio Vascular-Reval Disease</i>						<i>?</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <i>Senility</i>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>none</i>							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) (Minute) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>June 13, 1955</i> , to <i>June 19, 1955</i> that I last saw the deceased alive on <i>June 19, 1955</i> , and that death occurred at <i>5:40 A.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>John T. Harrington</i>		ADDRESS <i>AM 3810-12 NE Washington D.C. 6455</i>		DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Cremation</i>		<i>6/22/55</i>		<i>H. Lincoln Crematory</i>		<i>Dr. George Co. Md</i>	
DATE REC'D BY LOCAL REGISTRAR <i>June 20 1955</i>		REGISTRAR'S SIGNATURE <i>J. William Riddle</i>		24. FUNERAL DIRECTOR <i>L.H. Hines Co</i>		ADDRESS <i>2901 14th St N.W. D.C. Wash D.C.</i>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUN 21 1935

RECEIVED

5815

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>MONTGOMERY</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>MONTGOMERY</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>KENSINGTON</u>		<u>1 1/2</u>		TOWN <u>KENSINGTON</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>4007 DENFELD AVE.</u>				STREET ADDRESS (If rural give location) <u>4007 DENFELD AVE</u>			
3. NAME OF DECEASED:				4. DATE (Month) (Day) (Year)			
(Type or Print) <u>JOHN PHILLIP ZIER</u>				OF DEATH: <u>JUNE 2nd</u> 19 <u>55</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED.	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>MALE</u>	<u>WHITE</u>	<u>WIDOWED</u>	<u>SEPT. 1/1888</u>	<u>66</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life)				10B. KIND OF BUSINESS OR INDUSTRY:			
<u>POLICEMAN (RETIRED)</u>				<u>METROPOLITAN POLICE DEPT - WASHINGTON D.C.</u>			
11. FATHER'S NAME:				12. CITIZEN OF WHAT COUNTRY:			
<u>PHILLIP ZIER</u>				<u>U.S.A.</u>			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>PHILLIP ZIER</u>				<u>CARLISLE RICK</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give year or dates of service)				16. SOCIAL SECURITY NO.			
<u>NO</u>				<u>NONE</u>			
17. INFORMANT & ADDRESS:							
<u>MARY LOU ROBERTS - 4007 DENFELD AVE. KENSINGTON, MD</u>							
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<u>450.0</u>							
IMMEDIATE CAUSE							
(A) <u>Congestive Heart Failure</u>				<u>7 months</u>			
ANTECEDENT CAUSE (S)							
(B) <u>Arteriosclerosis, Hypertension</u>				<u>years</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C) <u>Chronic Pulmonary Emphysema & Bronchitis</u>				<u>years</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY?							
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5/25/55</u> , 19 <u>55</u> , to <u>6/2/55</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>6/1/55</u> , 19 <u>55</u> , and that death occurred at <u>2: A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Samuel Green</u>				DATE SIGNED <u>6/2/55</u>			
ADDRESS <u>M.D. Kensington, MD</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>JUNE 4/1955</u>		<u>GLENWOOD CEMETERY</u>		<u>WASHINGTON D.C.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>6/4/55</u>		<u>Bessie M. Thompson</u>		<u>W.W. Chambers Co - Riverdale, Md.</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUN 7 1955

RECEIVED